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Ways of knowing and caring for older adults: a qualitative study of baccalaureate nursing students' perceptions

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Ways of knowing and caring for older adults: A qualitative study of baccalaureate nursing students' perceptions

by

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For the Graduate College

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ABSTRACT

The growing population of older adults presents many challenges to nursing education. Curriculum design must attend to means that support students in a comprehensive approach to the often complex care that older adults require. The purpose of this qualitative study was to explore how baccalaureate nursing students come to know and understand care for older adults, and apply this student perspective to curriculum and practice issues related to gerontology nursing.

Eight recent graduates of a baccalaureate nursing program at a midwestern private liberal arts college were individually interviewed at two separate meetings. In addition, a document review was conducted of respondent-created assignments that were developed as learning tools throughout the student's undergraduate education. These interview transcripts and documents served as the data that were inductively analyzed through a constant comparative process of unitizing and categorizing. From this process four themes emerged that served to represent the data and provide the foundation for pattern analysis and interpretation. Trustworthiness was established according to Lincoln and Guba's (1986) criteria of soundness.

The four emergent themes were: (1) Experience as a Growing Foundation, (2) Ways of Being, (3) Contexts of Care, and (4) Teaching and Learning Care for Older Adults. These themes were consistent with established feminist pedagogy in that life experience, relationships, and multiple ways of knowing pervaded. Students came to know and understand care for older adults by constructing knowledge based on a variety of lived experiences within a variety of contexts. Experiences that both challenged and supported the students' development were

evident in the findings.

These baccalaureate nursing students came to know and understand care for older adults through connections made with their life experiences and developed relationships with patients, both in and out of school, primarily in community settings. While literature, as formal didactic, had an influence on these students' "knowing" regarding care for older adults, students' perceptions of "ways of being as a means of knowing", and "ways of being as a reflection of esteem" were dominant patterns in the data. These "ways of being as a means of knowing" older adults included relationship building, taking the time to get to know the older adult and listening to them, making connections, and trying to understand or empathize with their circumstances. "Ways of being as a reflection of esteem" conveyed the students' feelings about recognizing the uniqueness of the older adult, the need to be respectful, patient, open and accepting of them, willing to learn from older adults, to be open to the strength and potential that older adults have, to recognize their need for autonomy and independence, and to be their advocate. These ways of being within the context of both in and out of school experiences provide useful direction for teaching and learning care for older adults.

The themes affirm student development theory, multiple ways of knowing, and development of caring relationships. Recommendations to inform nursing curriculum development include facilitation of experiential learning situations that: (1) Foster relationship-building with the older adult, (2) Allow for active engagement and knowledge sharing in all teaching / learning experiences, and (3) Encourage reflection on and in action to support transformational learning opportunities and meaning-making.

CHAPTER ONE

OVERVIEW OF THE STUDY AND STATEMENT OF THE PROBLEM

Introduction

> Do not reject me now I am old,
> nor desert me now my strength is failing.
> Psalm 71: 9

> When Sadie was 103, she broke her hip and landed in the hospital and, honey, that's a situation worth worrying about...You know showing up at a hospital at 103 years old, no one wants to touch you. They don't know what to do with old folks, and they just assumed we were senile. They'd talk in front of us like we weren't there. It was mighty insulting.
> Elizabeth (Bessie) Delaney (1994, p. 121)

I have been a nurse educator for well into a second decade. The majority of my career has been at a small liberal arts college. Among the benefits of practicing as a nurse educator in this environment is the opportunity to develop a close relationship with students and come to know their career goals and dreams as they begin their nursing education and as they complete their baccalaureate degree. It has been my observation over the years that, although nursing student opportunities to care for patients included people of all ages, it was a rare senior student who would identify gerontology as the practice area she/he was going to pursue post graduation. Integration of gerontology content throughout the program of study and even a Gerontology Nursing course, which seemed to make a significant difference in student perception of care needs for older adults, ultimately was of no consequence in generating the same practice passion that pediatrics, critical care or the neonatal intensive care unit inspired. My observation has grown into a critical concern.

This concern stems from what are becoming well know statistics related to the aging population. Since 1900, the percentage of the U.S. population 65 years

of age and older has tripled. Projected growth of this population is from the current 12.5 percent to 21.8 percent by the year 2030. At that time, it is estimated that there will be 59 million elderly people in the United States. By the year 2010, 45 percent of the elderly population will be over 75 years of age (Wells, 1992).

Considering the demographics of our aging population, the following projection by Mahoney (1993) was not surprising: by the year 2020 almost 70 percent of time health professionals spend on patient care will be with individuals over the age of 70. Wells (1992) suggested that there will be an overall need for more than double the anticipated supply of baccalaureate prepared nurses and three times the anticipated supply of registered nurses with graduate degrees to meet the nursing care needs of the aging population.

How has baccalaureate nursing education responded to this health care challenge? Nursing curriculum focused on gerontology is a relatively recent trend. Literature related to the special care needs of the elderly only started appearing with regularity in the 1960s. Now, some 30 years later, there are Standards for Gerontological Nursing Practice (American Nurses Association, 1986 & 1995) and a growing body of gerontological nursing research (Burke & Sherman, 1993; Burnside, 1988). However this slowly growing emphasis on gerontology curriculum in nursing education seems to have had little effect on baccalaureate nursing students' attitudes toward gerontology as a preference for practice. Despite the advances in gerontology nursing, compared to other practice specialties, nursing graduates continue to desire acute care and other specialty areas as a practice preference with the gerontology specialty a "last choice" for most (Fullerton et al., 1992; Small, 1993; Felsen, 1993; Carr & Kazanowski, 1994). Robertson and Cummings (1996) believe this situation contributes to the long-

standing professional nursing shortage in long-term care for older adults. In addition, from a broader perspective, this practice reluctance has a direct impact on comprehensive health care delivery for the aging population including the development and implementation of effective health promotion measures.

There is increasing demand for the leadership potential baccalaureate prepared nurses have to offer in response to health care needs associated with changing demographics of the older adult population. Nursing leadership will be essential in providing the innovative, complex, holistic care older adults require. I was therefore interested in exploring how nursing education can attend to this social challenge of care for an aging population. I believe an important aspect is exploring how baccalaureate nursing students come to know and understand care for older adults. A better understanding of student perspectives would provide insights for gerontology health care issues and the rationale supporting students' practice preferences and goals. Knowledge gained from exploring this perspective will inform baccalaureate nursing curriculum development in gerontology and impact comprehensive health care delivery for an aging population.

Statement of the Problem

The purpose of this study was to explore how baccalaureate nursing students come to know and understand care for older adults, and in turn apply this student perspective to curriculum and practice issues related to gerontology nursing. Insights gained from exploring this perspective will inform baccalaureate gerontology nursing curriculum development and respond to the nursing care challenge posed by an aging population. The study also enriches understanding of the development of students' practice goals being inclusive of care for older adults or lacking this inclusivity. From the students' lived experiences, nurse educators

may shape new educational possibilities for students and ultimately enhance professional nursing practice within the scope of contemporary health care delivery.

The specific research objectives are:

1. to describe how baccalaureate nursing students come to know and understand care for older adults;
2. to describe significant aspects of the nursing students' way of being that influence how they come to know and understand care for older adults;
3. to describe and discuss the meaning that student perceptions regarding coming to know and understand care for older adults have for baccalaureate nursing curriculum; and
4. to describe and reflect upon the meaning of student perceptions related to their caregiving expectations and practice goals.

Recent graduates of a baccalaureate nursing program were interviewed individually with the intent of understanding the students' perception of how they have come to know and understand care for older adults and how these perceptions relate to caregiving expectations and practice goals. Student-created documents or written work from their recent nursing education experiences also were examined for additional insights into the student's development as a professional caregiver.

The research questions are as follows:

1. How do baccalaureate nursing students come to know and understand care for older adults?
    a. What role does relationship building play in the students' coming to know and understand care for older adults?

b. What role does life experience play in the students' coming to know and understand care for older adults?

c. What is the significance of caregiving context related to the student's coming to know and understand care for older adults?

2. Based on the nature of perceptions and existing literature, what teaching methods / tools might best nurture baccalaureate nursing students coming to know and understand care for older adults?

Significance of the Study

This qualitative study is significant in terms of (1) theory building, (2) practice application, and (3) policy development. Baccalaureate nursing education is designed to prepare students to practice in health care leadership positions. The aging population and the associated health care delivery demands have generated need for greater involvement of nursing leadership in planning and delivery of holistic care for older adults. Baccalaureate nursing graduates must be ready to respond to this health care demand, but the recent trend toward practice-related research in nursing has drawn the focus away from research regarding nursing education, the student perspective, and curriculum building. Consequently, very little is known about the contemporary baccalaureate nursing student's perceptions about care for the older adult.

Qualitative studies contribute an inductive approach to theory development by use of data grounded in the context of the study from which new meaning emerges (Merriam, 1988). Description of experiential learning and meaning making within the context of the baccalaureate nursing student perspective may generate new theories related to student learning in general and curriculum development in particular. In addition, by focusing on care for the specific

population of older adults, theory building may be encouraged regarding intergenerational views on ways of knowing and/or extension of theories on caring. Theories related to caring (Noddings, 1984; Watson, 1988; Benner & Wrubel, 1989; Bevis & Watson, 1989), ways of knowing / development (Belenky, Clinchy, Goldberger & Tarule, 1986; Carper, 1978; Gilligan, 1993), and to some extent coping (Lazarus & Folkman,1984; DeLongis & O'Brien, 1990) have emerged as a family of perspectives that have guided conceptualization of this study and support the sense of purpose (Wolcott, 1994).

This study also has implications for practitioners in nursing education. First, some clarity may be gained in identifying and understanding significant aspects of the students' lived experiences that inform their value of and approach to care for the older adult. In addition, insights gained from this study may be useful as faculty evaluate nursing curricula for both content regarding care for older adults and the processes by which students come to know and understand this care. As the population ages, nursing education must be vigilant of content and methods that nurture practitioners' value of care for older adults to support holistic, creative, and effective care.

Finally, policy, defined as "a definite course or method of action selected to guide and determine present and future decisions" (Merriam-Webster, 1974, p. 537), is interrelated with practice and theory. Theory that emerges from this study could be used to construct nursing education curriculum policies that, in turn, guide individual nursing curricula specifically and ultimately may influence policy development for older adults via nursing practitioners who value and are challenged by the care dilemmas of individuals in the later years of their life span.

Dissertation Overview

This dissertation consists of five chapters. In addition to the introductory chapter, Chapter Two includes further discussion of the research questions and a justification for the qualitative research approach. It also describes the methods used to conduct the study, including a review of a pilot project, identification of the participant selection process, and discussion of data collection and analysis methods. Rigor, trustworthiness, and ethical considerations are also detailed.

In Chapter Three, findings of the study are reported through detailed description. Emergent themes are developed to depict and organize the results, primarily using the respondents' own words to provide the thick, rich detail and context. Document review and my reflections on participant observation provide additional detail to findings described.

The data, grounded in the context of the study, are analyzed in Chapter Four. Analysis and interpretation will be presented as a coordinated interaction of the data based on apparent and strong links (Wolcott, 1994). This coordinated process will be informed by existing theory, prior research, and related literature. In qualitative inquiry, literature review is ongoing throughout the research process. Consequences of completing the literature review before data collection and analysis can include a prescribed focus and limitation of possibilities for emergent design (Denzin & Lincoln, 1994). Often the data suggest the need to review previously unexamined literature of both substantive and theoretical nature (Glesne & Peshkin, 1992). In this dissertation, contextualizing literature and theory will be woven throughout all chapters to reflect the dance with the literature that took place throughout this research process.

Finally, Chapter Five reflects my interpretations of the study. LeCompte and

Preissle (1993) note that interpretation is an invitation to think about things differently. In this final chapter I speak to my colleagues as I attempt to make sense of the study (Wolcott, 1994). It is here that I offer new perspectives for nursing education and nursing practice consideration as well as further research possibilities.

CHAPTER TWO

RESEARCH METHODS

Restatement of Research Questions

In qualitative inquiry, initial questions for research often come from real-world observations, dilemmas, and questions that have emerged from the interplay of the researcher's direct experience, tacit theories, and growing scholarly interests (Marshall & Rossman, 1995). In Chapter One, the purpose of the study was described including general objectives that will frame this exploration of how baccalaureate nursing students come to know and understand care for older adults. These research objectives and their corresponding questions were guided by existing theory, a review of the literature, the pilot project I conducted (Franzen, 1996), and my personal theories as a nurse educator. Tacit theory and formal theory help to bring the question, phenomenon or issue into focus or raise it to a more general level (Marshall & Rossman, 1995). Formal theories on caring (Noddings, 1984; Watson, 1988; Benner & Wrubel, 1989; Bevis & Watson, 1989), ways of knowing / development (Belenky, Clinchy, Goldberger & Tarule, 1986; Carper, 1978; Gilligan, 1993), and coping (Lazarus & Folkman, 1984; DeLongis & O'Brien, 1990) all underlie the research objectives for this study. Following are the four general research objectives reiterated from Chapter One.

1. Describe how baccalaureate nursing students come to know and understand care for older adults.
2. Describe significant aspects of the nursing students' way of being that influences how they come to know and understand care for older adults.
3. Describe and discuss the meaning that student perceptions regarding coming to know and understand care for older adults have for

baccalaureate nursing curriculum.

4. Describe and reflect upon the meaning of student perceptions related to their caregiving expectations and practice goals.

The following specific questions focus on the research objectives.

1. How do baccalaureate nursing students come to know and understand care for older adults?
    a. What role does relationship building play in the students' coming to know and understand care for older adults?
    b. What role does life experience play in the students' coming to know and understand care for older adults?
    c. What is the significance of caregiving context related to the student's coming to know and understand care for older adults?
2. Based on the nature of perceptions and existing literature, what teaching methods / tools might best nurture baccalaureate nursing students coming to know and understand care for older adults?

Methodology

Research Design Justification

The focus of the research and the questions to be considered guide the selection of the approach to inquiry (LeCompte & Preissle, 1993); and research that delves into description of context, setting, and participants' frame of reference or perceived reality is a good fit to qualitative research methods (Marshall & Rossman, 1995). This "good fit" is because qualitative research methods are supported by the naturalistic paradigm that portrays a world in which reality is not a fixed entity but rather socially constructed, complex, interrelated, and ever changing; reality exists within a context and many constructions are possible

(Lincoln & Guba, 1986; Glesne & Peshkin, 1992; Polit & Hungler, 1997). Qualitative inquiry is additionally a process or way of knowing that seeks meaning contained in context and embraces reflexivity between the researcher and the research participants (Altheide & Johnson, 1994).

> Epistemologically, the naturalistic paradigm assumes that knowledge is maximized when the distance between the inquirer and the participants in the study is minimized. The voices and interpretations of those under study are key to understanding the phenomenon of interest, and subjective interactions are the primary way to access them. The findings from a naturalistic inquiry are the product of the interaction between the inquirer and the participants. (Polit & Hungler, 1997, p.13)

Complex constructs and their processes (such as students' perceptions regarding how they came to know and understand care for older adults) are particularly amenable to qualitative research because words are used to provide detail in the descriptive data, with the ultimate goal being to understand the meaning of an experience (Merriam, 1988). In the applied field of nursing, qualitative methods are needed to study the whole of human experience, including the characteristics of a phenomena (Beck, 1995). For example, use of qualitative methods yields rich descriptions of what it is like to be sick, to be a patient, or to be an older adult in need of care. Comprehension and appreciation of these contexts provide opportunities for students to develop empathy and nurture care (Morse, 1991). Geertz (1973) refers to people being "suspended in webs of significance" (p.5) that they have spun. Analysis of the "webs" is a search for meaning. In this research, I am searching for the meanings that nursing students have ascribed to their experience of care for older adults. This search for meaning will necessarily involve discovering social constructions that are used by respondents, since adoption of the naturalistic paradigm enables researchers to accept an individual's

reality from different vantage points or perspectives and understand the multiple realities that individuals construct. "The meanings and wholeness derived from or ascribed to the tangible phenomena (the individual's perceived reality) in order to make sense of them, organize them, or reorganize a belief system,... are constructed realities" (Lincoln & Guba, 1985, p. 84). Using a naturalistic paradigm, constructivists or interpretivists believe that to understand the world of meaning one must interpret it. The goal is to understand "the complex world of lived experiences from the point of view of those who live it... the inquirer must elucidate the process of meaning construction and clarify what and how meanings are embodied in the language and actions of social actors" (Schwandt, 1994, p.118). Schwandt noted however, that to prepare an interpretation is itself to construct a reading of these meanings; to offer the inquirer's construction of the constructions of the individuals being studied.

Thus the interpretation or understanding of meaning and how this is socially constructed by the individuals being studied is the paradigm on which this research is premised. Because the search for patterns in respondents' meanings was of primary interest in this research, the use of qualitative methods informed by a social constructivist approach provided an appropriate framework for this study. The methods I selected permitted me, as the research instrument, to describe, analyze, and interpret the meanings the participants have constructed. These methods are described next.

Methods of Data Collection

Interviewing

In-depth interviewing described as "a conversation with a purpose" is one of the specific methods that was used in this study to explore the essence of the respondents' perceptions (Marshall & Rossman, 1995, p. 80). This interviewing process was conducted as a conversation exploring the participants' perceptions based on their responses to a predesigned semi-structured interview format (See Appendix A for General Interview Format). Although this conversation explored predetermined general topics, I was sensitive to respecting how each participant framed and structured their responses, allowing for exploration of other emergent considerations. Using this descriptive methodology, I explored general topics relating to care for older adults to help uncover the participants' perspectives on meaning and their perceptions regarding their experiences.

Document Analysis

In addition, student-developed documents produced during the course of their nursing education were gathered and analyzed to supplement the in-depth interviewing. These documents included journals, nursing care plans, and projects prepared for various courses in the nursing curriculum. Such a review of documents is not only an unobtrusive method of data collection but one rich in portraying the values and beliefs of participants in the setting (Marshall & Rossman, 1995). Content analysis of the documents proceeded in a manner similar to the analysis of the in-depth interviews (which will be described completely under the data analysis section later).

My experience with qualitative research methods supports this selected approach to inquiry. A pilot project that was the catalyst for this research

provided me with practice in qualitative methods and affirmed my decision that a qualitative approach to inquiry was essential to the nature of this study. In addition to the experience gained conducting my pilot project, I have conducted and analyzed data from several focus groups. These focus groups were conducted for program evaluation purposes in the education setting and provided much insight into collecting and analyzing qualitative data. These prior experiences satisfactorily prepared me for conducting this study. Because of its direct relevance to the proposed study, a brief description of the pilot project methods and conclusions follows.

Pilot Project Description

In the summer of 1996, I conducted a pilot project as a requirement for a course on qualitative inquiry (Franzen, 1996). The focus of the project was to explore and begin to describe how baccalaureate nursing students come to know and understand care for older adults. A general literature review was conducted to set the stage for the project and included references describing a range of content and methods used for undergraduate curricula in gerontology nursing. Recent concerns about gerontology nursing curricula were associated with meeting the potential health care needs of our aging population (Mahoney, 1993; Gioiella, 1993; Beyea, 1993; Halloran & Dean, 1994). Teaching methods to affect student attitudes and knowledge have been explored with varied issues identified such as frequency / focus of experience with older adult patients, and placement of gerontology content within the curriculum. A range of recommendations were made such as: integration of gerontology content throughout the program of study, specific gerontology courses created as required or elective offerings, clinical practica in varied sites, and goals for care ranging from specific technical skills to a

management focus (Taft, 1986; Hogstel, 1988; Verderber & Kick, 1990; Nelson, 1992; Earthy, 1993;Matzo & O'Reilly, 1993; Matzo, Perrin & Williams-Burgess, 1993; Philipose, 1993; Stumpf, Wollman & Mezey, 1993; Yurchuck & Brower, 1994; Sheffler, 1995). Very little qualitative research was published in this area although a few studies included anecdotal data in their reports of survey results (Robertson & Cummings, 1996; Fox & Wold, 1996). Although determining the best time to conduct a literature review is a matter of debate, this general literature review supported the task of becoming familiar with the background of the topic and exploration of theories that match with or elaborate on the phenomenon chosen for study (Glesne & Peshkin, 1992; LeCompte & Preissle, 1993). "A literature review's impact on problem formulation is an interactive process" and as such assists the researcher in determining whether to proceed inductively or deductively (Merriam, 1988, p.63). My desire to explore student perceptions and their meaning primarily through the description and analysis of their stories meant that an inductive approach to inquiry was chosen.

Two students were interviewed about their experiences and perceptions about care for older adults. Both students had graduated from the same baccalaureate nursing program two months prior to the interview. The nursing program they had completed was in a small private liberal arts college in a medium sized city in the midwestern United States. Both respondents were female, Caucasian, and in their mid-twenties.

Open-ended interviews were conducted with questions developed to facilitate students' conveying the evolution of their perceptions of care for older adults. A few of the items were inspired by the Interview Schedule from Belenky, Clinchy, Goldberger and Tarule's Women's Ways of Knowing (1986).

The interview questions were as follows:

1. Looking back over your whole life, can you tell me about a really powerful learning experience that you've had in or out of school related to care for older adults?
2. What meaning did this experience have for you?
3. What does "care for an older adult" mean to you?
4. In your learning about care for older adults, have you come across an idea that made you see things differently?
5. What will stay with you?
6. What has been most helpful to you in coming to know and understand care for older adults?
7. Are there things that you haven't learned (in school) that are important to you related to care of older adults?
8. Are there things you would like to learn that you can't learn at school?
9. How do you know how to care for older adults?
10. How have you come to know how to care for older adults?
11. What feelings do you have about caring for older adults?
12. What is important to you in caring for an older adult?
13. What do you like most and least about caring for older adults?
14. What is important about learning to care for older adults?
15. Tell me about a time when you came away from a care experience with an older adult thinking "I'm never going to forget this experience because....."
16. What are some of the issues related to care for older adults that have affected you?
17. Are there any other questions I should have asked you to help me

understand how you have come to know care for older adults?

18. Would you consider a practice area that involved care for older adults?

Responses to the interview questions were unitized and categorized. These are processes that will be fully described in the research design section immediately following. Four themes emerged from the pilot study data. These themes were: (1) experience, (2) relationship, (3) listening, and (4) caring. Each theme depicted a concept that represented the student's perception of how they came to know and understand care for older adults.

A document review was included in the pilot design as an additional data source and as a data triangulation strategy (Lincoln & Guba, 1986). The respondents were requested to bring to the interview any written documents from their previous school work that would reflect their knowing and understanding the dimension of care being studied. The intent was to review such traditional educational assignments as nursing care plans, papers or journals regarding care experiences. One of the two respondents provided such documents. In reviewing these documents I noted that one, a concept paper, reflected some of the same themes that had been identified in the interviews. Of greater interest was what was missing in the remaining documents that the student provided. These other documents are referred to as Care Plans and are the written plan of care or strategies a student creates in preparation for an actual patient care clinical assignment. None of the care plan documents provided by the student reflected any of the themes that were revealed in the interviews. This discovery caused me to question what teaching methods / tools might best nurture the students' coming to know and understand care for older adults and incorporate these

understandings into their clinical practice. This discovery also reinforced the significance of multiple data sources in addition to the primary interview method and assisted me in recognizing the data that would be valuable for my intended purpose (Wolcott, 1994).

The pilot project provided opportunity to practice using qualitative research methods as well as contribute insights into ways a subsequent, larger study could be refined. For example, I found that several of the original questions I had developed were interpreted as asking the same thing. These items were noted and refined to be clear as to the intent of the question. In addition, I had not anticipated the concept of "experience" would be the significant theme and pattern that it was in this pilot project. I question if using this word in some way was "leading" or was interpreted as what I, as the interviewer, believed was a preferable answer (LeCompte & Preissle, 1993). This wording was given further consideration in subsequent data collection by substituting the word "situation" in the interview questioning.

Another example of refinement of the design is related to the significance of "life experience" for the respondents. Although unintended, in the process of the interviews, I became aware that one of the respondents had a great deal of life experience with older adults, which she brought to her nursing education. The other respondent did not have similar life experiences. Life experience and associated relationships, based on these two perspectives, seemed to provide both a pattern (distinct arrangement in the connection of the data categories) and a theme (essence of the connected data categories) in these pilot interviews. My comparison of the two respondents' transcripts prompted thoughts about exploring with the respondents any life experiences with older adults as a potential path for

the respondents' learning about care for older adults. Coming to understand better the significance of life experience, in relation to how the respondents came to know and understand care for older adults, may provide additional rich insights. This insight further directed subsequent review of the literature. Experiential learning (Bevis, 1989; Diekelmann, 1990; Benner, 1991; Benner, Tanner, & Chesla, 1992; Eyres & Ersek, 1992; Jackson & MacIsaac, 1994; Lewis & Williams, 1994; Mitchell & Heidt, 1994; Davies, 1995; Kuh, 1995), relationship building (Bishop, 1990; Jenny & Logan, 1992; Jenks, 1993; Kramer, 1993; Johns, 1995; Kosowski, 1995), and intergenerational issues related to care (Brody & Schoonover, 1986; Baltes, 1987; Henretta, 1988; Gatz, Bengston, & Blum, 1990; Kayser-Jones, 1993; Nordgren & Johnson, 1995; Scheffler, 1995; Evans, 1996; Fox & Wold, 1996; Marks, 1996) were explored as additional grounding concepts that have been incorporated into this study's foundation and will be further explored in the data analysis presented in Chapter Four.

A final example of method refinement based on the pilot study relates to my discovered need to do follow-up questioning of the respondents for clarification of transcript data and the opportunity to pursue additional elements I gave consideration to after reviewing the transcripts. I determined a second interview for each respondent would also allow them the opportunity to reflect on the initial interview and perhaps generate other thoughts as a result of this time for reflection (Schon, 1987; Bloom, 1996). Both of these insights caused me to modify my interview design.

My preliminary review of the literature found no published qualitative studies that explored how baccalaureate nursing students come to know and understand care for older adults. I believe the pilot project illustrated the rich

possibilities inherent in the exploration and description of student perceptions regarding this phenomena. Because of my experiences with the pilot project and as a result of the preliminary and subsequent literature reviews, I modified the study in the following ways: I broadened my approach with the interview questions, allowing opportunity to explore the areas of experiential learning, relationship building, and intergenerational care. I included a second interview with each respondent as a means of clarification of response detail and an additional data collection opportunity. In addition, I broadened my range of possibilities of document retrieval to include additional sources of written data for review and content analysis.

Research Design

Site and Participant Selection

According to Marshall & Rossman (1995), the ideal site is where (1) entry is possible; (2) there is a high probability that a rich mix of the processes, people, programs, interactions, and structures of interest are present; (3) the researcher is likely to be able to build trusting relations with the participants in the study; and (4) data quality and credibility of the study are reasonably assured.

To meet the site considerations discussed above, I chose to recruit participants from among recent graduates of a baccalaureate nursing program at a midwestern private liberal arts college. This site was specifically selected as access and a trusting relationship with participants was likely since I am a faculty member. In addition, my prior knowledge of the rich mix of the processes, people, and programs at this site supports data quality and credibility of the study. No additional sites were utilized as methodological rigor was achieved by increasing the depth of the data collected rather than breadth of numbers or sites: "In depth,

rather than breadth, we realize the promise of qualitative research" (Wolcott, 1994, p. 184).

Selection of recent graduates as participants supported data quality and credibility in that these respondents had completed their undergraduate education and could draw on this as a primary context for their perspective. In addition, I believed recent graduates were more likely to be genuine in their interview response once relieved of what may be perceived as vulnerability of the student role (LeCompte & Preissle, 1993). I selected eight recent graduates of this nursing program with the intention of collecting data until informational redundancy was achieved (Lincoln & Guba, 1985). The point of redundancy is defined as "the point at which efforts to net additional members cannot be justified in terms of the additional outlay of energy and resources" (Lincoln & Guba, 1985, p. 233). This informational redundancy was accomplished through emergent response analysis. As my emphasis was on capturing the essence of the phenomena, the participant selection process evolved as I looked for depth of data necessary to satisfy the intended purpose of the study. I believe the eight respondents, in addition to the two pilot study respondents, provided the depth of data to which I was striving.

Data Collection Methods

As the sole researcher, I conducted in-depth, semi-structured, face-to-face interviews with each participant. Participant consent for audiotaping the interviews was obtained. I employed a reflexive dialectic technique during the interviews. This technique involved a dialectical process among the researcher and the participants' constructs, the emerging research data, the researcher's ideological biases, and the structural and historical forces that informed the phenomena being studied (Anderson, 1989). In this manner I discussed and verified data provided

during the interviews and asked for clarification at appropriate times. I attempted to avoid suggestive or leading questions and kept observational notes during the interviews to refer back to periodically for clarification and summation.

In addition, I collected respondent-created documents that were developed as learning tools throughout the participant's undergraduate nursing education. These documents were solicited during participant recruitment. Glesne and Peshkin (1992) note that documents corroborate observations and interviews and as such contribute to trustworthiness. Participants had sole decision-making on number and type of documents to be submitted although I did encourage a variety of examples including student journals, papers, and other learning tools created throughout their nursing education experience.

As the researcher, I was the instrument through which the data were collected as a sensitive observer, storyteller, and writer (LeCompte & Preissle, 1993). I attempted to collect the data in a manner that would make the familiar strange: I tried to look at events, behavior patterns, interactions, and documents "afresh and understand them and their consequences in a new light" (LeCompte & Preissle, 1993, p. 115).

As the sole research instrument, I must also acknowledge researcher subjectivity. Qualitative research is distinguished partly by its admission of the subjective perception and biases of both participants and researcher into the research frame. LeCompte and Preissle (1993) noted that researcher subjectivity serves several purposes that are not necessarily presumed to be a source of bias or error: (1) it permits affective reactions to what is being observed, which may serve as significant clues to things that need to be further examined; (2) it is essential to establishing and building relationships with participants; and (3)

subjective reactions and responses are often the source for emergent methodological decisions. On several occasions my reaction to student responses and the documents they submitted gave cause for me to clarify and further examine certain aspects of the students' reflections. This proved to be valuable in the methodological process of this study.

To track the data chronologically, a field log was be kept throughout the study. The primary recording tool of the qualitative researcher, the field log included descriptive notes regarding people, places, events, activities, and conversations; and it became a place for ideas, reflections, hunches, and notes about patterns that seem to be emerging (Glesne & Peshkin, 1992). The field log included descriptive notes as well as interview transcripts. In the early stages of data collection, data were recorded descriptively and comprehensively (Mariano, 1990). Interpretation and selective emphasis followed as the fieldwork and analysis progressed.

The log was updated as soon as possible following data collection so that "the essence of the encounter is not lost" (Mariano, 1990, p. 357). Throughout the study I also made detailed notes in the log to track my decisions regarding data collection, procedures involved in data analysis, and analytic and / or interpretive memos. Frequent referrals to the log, content literature, and methodological literature directed my decisions on how best to proceed.

Data were collected through indepth interviewing (the primary technique) and examination of documents. These techniques have relevance to this study and are described in detail next.

Interviewing

Interviewing helps gather specific information, described as "what is in and on someone else's mind" (Merriam, 1988, p. 72). In this study, this technique facilitated gathering respondent perspectives that, I believe, could not have been achieved as well through any other research method. I asked "how" and "why" types of questions to elicit complex responses about feelings and perceptions--specifically about how the respondent came to know and understand care for older adults. My role additionally involved doing justice to the complexity of the social interaction and respecting it in its own right. "The gift of personal presence is being able to tell the stories of our others" (Glesne & Peshkin, 1992, p.8).

The format of the interview was open-ended and semi-structured, yet guided by a list of questions designed to elicit certain information from all respondents (Merriam, 1988). By utilizing a somewhat unstructured format, I could be responsive to what was happening in the interview, allowing the respondent's perspective to unfold as she viewed it, not as I viewed it (Marshall & Rossman, 1995).

In this study, initial interview questions were developed from (1) the research objectives and questions; (2) my personal knowledge and experiences as a faculty member in the nursing discipline; (3) a preliminary review of the literature, and (4) the interviews and document analysis from the pilot project I conducted (See Appendix A: General Interview Format).

Participants were interviewed at two separate meetings. During the first meeting rapport was established as the semi-structured interview was conducted. Also at this time documents were collected from participants. A subsequent meeting date was set to allow for rapport building and provide opportunity for

participants to reflect and respond a second time to previous questions providing any additional thoughts. This second meeting also provided me with an opportunity to direct clarification of earlier questioning and achieve illumination of the information provided during the first interview and from the documents. For example, several participants were asked to clarify or expand upon certain aspects of the initial interview and / or documents they provided. This clarification often triggered additional interview questions that served to elicit details on further perspectives. The second interview also provided an opportunity for respondents to reflect on a broader perspective of how they have come to know and understand care for older adults. These spaced meetings revealed additional perspectives the participants were able to share having been given the opportunity for reflection over time.

Each interview was audiotaped (following respondent consent) so that all information could be documented and repeatedly studied during analysis. Verbatim transcripts of each interview were produced. During and following each interview, I recorded notes reflecting on additional interview questions that I thought might be appropriate and any concerns that arose during the interview.

After reviewing these notes and interview transcripts, I used this information to complete interview summary forms (Logan, 1994; See Appendix B). The interview summary form helped organize information so that reactions to the interview, themes, and points of clarification could be identified; questions for subsequent interviews were also developed from this information. "Writing such a summary helps the researcher to withdraw from minute details and look for the larger picture that emerges" (LeCompte & Preissle, 1993, p.237). The summary also facilitated what Guba (1978) calls convergence: figuring out what data fit

together, either because the investigator believes they should or because the participants say they do.

To complement the data collected from interviewing, I also recorded observations made during each interview. These observations included non-verbal behavior that was consistent or inconsistent with what the respondents were telling me. Kinesics or the study of body motion communication can attach additional meaning to spoken words (Marshall & Rossman, 1995). If I sensed an incongruence between expression or body motion and what the respondents were saying, I noted this and asked for clarification. For example, if a respondent was discussing what they enjoyed about care for older adults yet their body language conveyed lack of comfort or distress, I would ask for clarification.

Document Analysis

Document examination is the second data collection technique that was used in this study. Documents provide information that is "grounded in the contexts they represent" (Lincoln & Guba, 1985, p. 277). In addition they may generate other pertinent questions for interview or insights relevant to the research questions that help to inductively build categories of data for analysis (Merriam, 1988). I requested that participants bring pertinent documents with them to the first interview. This request yielded pieces of representative work from five of the eight students. These documents included journal entries from a semester's coursework in two nursing courses, a care plan that was created for a patient over the span of several weeks, a creative project, a community final project, two esthetic projects, and two research articles that were significant to one of the respondents. These documents were reviewed and the information collected from them facilitated description of the context of the research and often generated trigger questions for

the follow-up interview. Document summary forms (Logan, 1994, Appendix C) were completed for each collected piece.

Data Analysis

Data analysis entails "the process of bringing order, structure and meaning to the mass of collected data" (Marshall & Rossman, 1995, p. 111). Qualitative research is differentiated from other approaches to inquiry by the timing of analysis and its integration with other research tasks. For example, feedback from respondents often focuses research questions as the researcher gains deepened understanding of the phenomena being studied and learns the meanings participants attach to things (LeCompte & Preissle, 1993). The reflexivity or interaction and interdependence of these processes is linked with the qualitative design (Altheide & Johnson, 1994). Wolcott (1994) describes the interaction between analysis and interpretation as a coordinated give and take resulting in links to the data which must be apparent and strong. In this study, analysis of data occurred concurrently with and after data collection. Clarification of respondent reflections as well as gleaning additional respondent thoughts were definite benefits of the social reflexivity in the process.

Data analysis is an inductive process. According to Lincoln and Guba (1985) the inductive analysis arises "from specific, raw units of information to subsuming categories of information in order to define local hypotheses or questions that can be followed up" (p.203). Initially, all of the collected data (audiotaped interviews, transcripts of interviews, interview summaries, documents provided by participants, document summaries, and field notes) were reviewed so that I was able to have a sense of the data as a whole. This initial review allowed me to relocate the original questions and scan the data for completeness as well as

to be reacquainted with the "territory previously covered" and obtain the "wisdom of hindsight" (LeCompte & Preissle, 1993, p.236). During this process a primitive outline or system classification was generated through a search for preliminary patterns. Then, inductive data analysis was completed through use of a constant comparative process (Glaser & Strauss, 1967) which consisted of unitizing and categorizing data.

Unitization organizes the data into manageable pieces or chunks. Ultimately, these units served as the basis for category definition (Lincoln & Guba, 1985). Lincoln and Guba (1985) further define a unit as having two characteristics:

> First, it should be heuristic, meaning aimed at some understanding of some action that the inquirer needs to have or to take, and second, it must be the smallest piece of information about something that can stand by itself. (p. 345)

Categorization of the study data proceeded after all of the data were unitized. This process was used to group units together that related to the same content (convergent categories) and to create distinct categories that were culled from each other (divergent categories) (Merriam, 1988). The process of categorization was completed through a method called constant comparison (Glaser & Strauss, 1967). In this method, one unit of information was compared to the next and then a determination was made whether the content was similar; if perceived to be similar it was placed in the same category, if not, a new category was created. Each new unit was compared to previous provisional categories to determine fit. If a unit did not fit, it was assigned to a new category.

> Thus the discovery of relationships ... begins with the analysis of initial observations, undergoes continuous refinement throughout the data collection and analysis process, and continuously feeds back into the process of category coding. As events are constantly compared with previous events, new topological dimensions as well as new relationships

may be discovered. (LeCompte & Preissle, 1993, p. 256)

Once a substantial number of units were collected into a category, descriptive statements were written that characterized the category. After all units were compared, categories were examined for overlap, for missing categories, and for needed subdividing or subsuming under other categories (Lincoln & Guba, 1985). (See Table 1.)

Table 1. Definitions of Data Organization Divisions

According to Marshall and Rossman (1995), "Data analysis is the process of bringing order, structure, and meaning to the mass of collected data" (p. 111). The following definitions depict how the data in this study were organized.

Unit: A unit is the smallest piece of information about something that can stand by itself (Lincoln & Guba, 1985). In the initial "tearing down" of the respondent transcripts, narrative was sorted into units. This divergent process was an approach to discover as many specific raw units of information as possible. Ultimately, the units served as the basis for category definition.

Category: A category is a grouping of units that has internal convergence and external divergence (Guba, 1978). Categories should be internally consistent but distinct from one another. In categorization, an attempt is made to identify the salient, grounded categories of meaning, held by participants in the setting (Marshall & Rossman, 1995).

Theme: A theme is the essence of what is represented in the synthesis of connected categories. Creating themes is a convergent process of finding meaning within the categories of data. This process draws the categories together to get a sense of what is "typical" of the phenomenon being studied (Polit & Hungler, 1997).

Pattern: An arrangement; a combination of actions or qualities that always happen the same way or in the same order (Webster, 1984). In this study a pattern represents a reoccurring relationship between categories within a theme. Relationships among categories emerged which remained within the essence of the theme, yet created distinct arrangements in the connection of the categories in that theme.

The goal of categorization is "development of conceptual categories ... that interpret the data for the reader" (Merriam, 1988, p. 133). Data analysis at this point moves to a more abstract level as salient themes, recurring ideas, and patterns in the data are identified (Marshall & Rossman, 1995). As conceptual categories emerged, I searched for those that had internal convergence and external divergence (Guba, 1978) such that the conceptual categories were internally consistent but represented distinct meanings held by the participants (Marshall & Rossman, 1995). Patterned arrangements clustered the categories. Patterns are more inferential and explanatory than the descriptive categories, and they illustrate an emergent pattern discerned in events and relationships" (Miles & Huberman, 1994, p. 57). Themes, as the principles or essence of the experience, followed from the patterns and were the basis for inference and interpretation as I attempted to bring meaning and insight to the words and acts of the participants in the study (Marshall & Rossman, 1995). (See Table 2.)

Trustworthiness

Trustworthiness is a term that denotes methodological rigor. Within the naturalistic paradigm, trustworthiness is established by asking the following question, "How can an inquirer persuade his or her audiences that the findings of an inquiry are worth paying attention to, worth taking account of?" (Lincoln & Guba, 1985, p. 290). There are four criteria that, if met, establish trustworthiness. These criteria of soundness are: credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1986; Marshall & Rossman, 1995). The application of these criteria to this study are discussed next.

Table 2. Data Depicted as Categories and Patterns within Four Themes

1. Experience as a Growing Foundation
    - A. Experience to Support a Growing Foundation
        - Experience / Opportunities in General
        - Early Childhood Experience
        - Role Modeling
        - Experience that Nurtured Confidence
        - Experience Over Time
        - Relating Experience to Relatives and Self
    - B. Experience to Challenge a Growing Foundation
        - Understanding Loss and Loneliness
        - Dealing with Death and Grief
        - Personal Feelings of Loss
        - Experience that Shakes Confidence
        - Frustration
2. Ways of Being
    - A. Ways of Being as a Way of Knowing the Older Adult
        - Developing a Relationship
        - Getting to Know Them
        - Enjoying Their Stories (Listening to Know Them)
        - Listening
        - Trying to Understand / Empathizing
        - Making Connections
    - B. Ways of Being as a Reflection of Esteem
        - Recognizing the Uniqueness of Needs
        - Respect
        - Patience
        - Learning from the Individual
        - Acceptance
        - Recognizing Strength and Potential in Aging
        - Promotion of Independence and Autonomy
        - Advocacy
3. Contexts of Care
    - Family
    - Life
    - School
    - Hospital
    - Community
    - Work
    - Nursing Home / Retirement Center
4. Teaching and Learning Care for Older Adults
    - Relationship Building
    - Value of Early Childhood, Family, and Life Experiences
    - Making Meaning

Themes 1 and 2 include patterned arrangements of categories.

Credibility

The goal of credibility is to demonstrate that the inquiry was conducted in such a manner as to insure that the subject was accurately identified and described (Marshall & Rossman, 1995). Credibility is established when the researcher is able to demonstrate that the multiple realities discovered and interpreted during the study are accurate portrayals; that these constructed realities depicted in the study originated in the multiple realities that are being studied (Lincoln & Guba, 1986). To meet the credibility criterion, methods of inquiry must be appropriate and lead to credible findings. These findings must also be confirmed by the respondents who constructed the multiple realities being studied. Marshall & Rossman (1995) recommend the researcher provide an in-depth description showing the complexities of variables and interactions that are so embedded with data derived from the setting that it cannot help but be valid. Techniques used in this study to enhance credibility were: prolonged engagement in the field, triangulation of data, thick and rich description of the phenomena, peer debriefing, and member checks.

Prolonged engagement in the field facilitates identification of saliencies in the situation and establishing trust of respondents (Lincoln & Guba, 1986). To accomplish prolonged engagement in the field, I conducted on-site interviews with each respondent twice. I endeavored to spend enough time with each respondent that they would have ample opportunity to respond to the interview and be able to reflect as needed in response to: the open-ended nature of the questions, additional probing questions to facilitate further reflection, the closing question of "is there anything else you want to tell me," and a follow-up interview that could capture additional reflection on the phenomena.

Triangulation is the act of bringing more than one source of data to bear on a

single point (Marshall & Rossman, 1995). Data from different sources can be used to cross-check accuracy as well as to "enhance the scope, density, and clarity of constructs developed in the course of the investigation" (LeCompte & Preissle, 1993, p. 48). In this study triangulation was achieved by (1) the use of different data collection sources, specifically interviews, observations, and documents (i.e., I compared the information found in the documents supplied by the respondents with the information I received from the respondents during the interviews) and (2) the use of multiple participants' response to interview items (i.e., all respondents were asked questions from the same semi-structured interview guide.)

Another credibility technique is called peer debriefing. Use of this technique involves a research peer to critique the study's findings and suggest improvements to make the investigator "as fully aware of his or her posture and process as possible" (Lincoln & Guba, 1985, p. 308). For this study, I arranged for a doctorally-prepared nurse educator who had completed a qualitative dissertation to serve as a peer debriefer. She studied the research design, analysis plan and findings, and provided a critique of the study at several points throughout the process.

Finally, to discover directly if the findings and interpretations were credible, I consulted with the respondents who constructed the multiple realities that I recorded in the transcripts. This procedure to assure accuracy of recorded data is referred to as "member checking" and was done throughout the study in several ways.

First, during, and immediately following each interview, I clarified and summarized thoughts and feelings of the respondents. Second, I requested that each respondent read her interview transcript and the summary form to confirm the accuracy and / or point out inaccurate data. Respondents completed this process

at the time of the second interview and provided feedback to me verbally at that time. The respondents were also mailed copies of their second interview transcript and the completed summary. A letter was sent requesting the respondent to contact me if the interview transcripts or summary was discovered to be inaccurate. Finally, a draft of the results with a self-addressed stamped envelope was mailed to all respondents requesting them to review the results and return corrections and/or additions to me.

Dependability

The criterion of dependability challenges the researcher to account for changing conditions in the phenomenon chosen for the study as well as changes in the design created by increasingly refined understanding of the phenonemon (Marshall & Rossman, 1995). Dependability focuses on consistency of methodological decision-making throughout the study. The inherent assumption here is that the social world is in a constant state of change or construction challenging replication in its strictest sense. The method that was used to satisfy the dependability criterion was the creation of an audit trail, defined as "a residue of records stemming from the inquiry" (Lincoln & Guba, 1985, p. 319).

In this study, the audit trail consisted of: (1) the raw data, which included tapes, transcripts, interview notes, and documents; (2) the processes and products of data analysis, which included the log, interview summary documents, field notes and notes on peer debriefing sessions; and (3) data synthesis, including descriptions of categorizations of data into themes and the final descriptive report. This audit trail will allow others to view the processes and products of the study easily.

Confirmability

The criterion of confirmability asks the question "Do the data help confirm the general findings and lead to the implications?" (Marshall & Rossman, 1995). Lincoln and Guba (1985) stress that evaluation of confirmability of the research be placed squarely on the data themselves. In addition to the audit trail technique referred to above, additional methods used to respond to the confirmability criterion included:

1) a peer debriefer who questioned the process and analysis critically; 2) the practice of value-free note-taking (i.e., taking two sets of notes, one with more descriptive observation and another that allowed me to "impose some conceptual scheme or metaphor, and to be creative with the data in ways that might prove useful for more formal analysis" (Marshall & Rossman, 1995, p.145); and 3) following the guidance of previous researchers to establish quality (i.e., my committee chair and a colleague have recently completed qualitative dissertations and were called upon to provide insights regarding data quality).

Transferability

Transferability refers to whether or not the research is useful in another situation. Marshall and Rossman (1995) proposed that "the burden of demonstrating the applicability of one set of findings to another context rests more with the investigator who would make that transfer than with the original investigator" (p. 143). This decision entails judgments about the relevancy of the original study to the new setting being considered by another investigator, assuming adequacy of data detail to make these judgments.

The transferability criterion was addressed in this study in three ways. First, consistent reference was made back to the original theoretical framework to show

how data collection and analysis were being guided by these concepts. According to Marshall and Rossman (1995), by doing so, "those who make policy or design research studies within those same parameters can determine whether or not the cases described can be generalized for new research policy and transferred to other settings, while the reader or user of specific research can see how research ties into a body of theory" (p. 144).

Triangulation of multiple sources of data is another strategy to enhance a study's transferability (Marshall & Rossman, 1995). Triangulation of sources was discussed above as an additional measure to insure credibility of this study, and according to Marshall and Rossman (1995), "Designing a study in which multiple cases, multiple informants, or more than one data gathering method are used can greatly strengthen the study's usefulness for other settings" (p. 144).

A final strategy to address the transferability criterion was the use of thorough description in the final report of findings. I believe the thick and rich description created a foundation for assessing transferability; that is, for making decisions about whether or not the research is useful in another situation (Lincoln & Guba, 1985). In addition to the use of thick and rich description of the participant responses, I also included the context or setting of the study with explicit information in the written synthesis to allow the reader to decide transferability.

Ethical Considerations

Ethical considerations in the conduct of qualitative research include generic issues such as informed consent and protecting participants' anonymity as well as situation-specific issues related to the context of the study (Marshall & Rossman, 1995). These situation-specific ethical considerations must be woven into the trustworthiness of the research methods. In the process of establishing

trustworthiness, ethical principles must be maintained. Many of the ethical concerns are context-bound, arising out of specific instances in each study (Glesne & Peshkin, 1992). House (1990) asserted three basic principles that must be considered in qualitative studies--the principles of (1) mutual respect, (2) noncoercion and nonmanipulation, and (3) support for democratic values and institutions. A description of ethical considerations in data collection, analysis and dissemination of findings with respect for these principles is presented next.

The research project was approved by the Iowa State University Human Subjects Review Committee (see Appendix D). Upon committee approval of this proposal, participants were recruited from the most recent graduates of the baccalaureate nursing program at the approved, predetermined site. It was anticipated that respondents may have felt a school related coercion associated with participation and their interview response. Therefore, a conscious decision was made to recruit students post graduation to minimize the possibility of coercion. Data collection was preceded by the respondents' reading and signing an informed consent form (see Appendix E). This document stated the purpose of the research, explained uses of the interview information, assured confidentiality, and affirmed the respondents' rights to withdraw from the study for any reason.

Respect for the participants was also demonstrated prior to the start of the data collection as the respondents were made aware of the nature of their participation and how findings would be used. The data collection site (the small private college from which respondents had graduated and at which I am employed) and circumstances that minimized the need for boundary spanning facilitated establishment of rapport and the creation of a comfortable setting. This rapport and comfort conveyed respect for the participants by supporting the

process of genuine interaction and appreciating respondents as valued contributors to the process of this inquiry. Every effort was made to respect the trust that was established with respondents throughout the course of their participation.

The researcher's role as the data collection instrument posed additional ethical considerations since the data is filtered through the lens of the inquirer and as such presents opportunities for exclusion of data that are in conflict with the inquirer's positions (Merriam, 1988). This manipulation issue was addressed through the use of careful note-taking and adherence to thick and rich description to allow the readers to draw their own conclusions as they also examine my conclusions. In addition, a peer debriefer was used to examine the conclusions for inconsistencies (Logan, 1994).

Participant confidentiality was addressed through the use of pseudonyms to represent respondents and their transcripts. Pseudonyms were also used to represent any patients the respondents referred to during the data collection. In addition, respondents were given the opportunity to view a draft of the final report prior to dissemination to demonstrate that anonymity was maintained. Finally, due to the emergent nature of a qualitative approach to inquiry, it was anticipated that ethical considerations could emerge that I would consider my personal and professional responsibility to address through the duration of the study (Wolcott, 1994; LeCompte & Preissle, 1993). I was prepared to draw upon student counseling services as a resource for dealing with any concerns. This process was upheld.

Reciprocity Considerations

Reciprocity involves the researcher's sensitivity to the intrusion of qualitative research into settings and respondents' lives as well as the adjustment of the

respondents' routines and priorities as they give of themselves to help the researcher (Marshall & Rossman, 1995). To maintain respect for the respondents, the researcher must acknowledge them as partners in the inquiry (Lincoln & Guba, 1986). The researcher's indebtedness to the respondents' willingness to enter into this partnership should fit within the constraints of the research and personal ethics of the researcher. Marshall & Rossman (1995) suggest it may include giving time to help out, providing informal feedback and being a good listener. I was sensitive to the intrusion of the study into the lives of the respondents and endeavored to facilitate as convenient an arrangement as possible for them throughout the process. I allowed for time for rapport-building at the beginning of each interview and also allowed for respondent feedback throughout the research process. I was sensitive to this dynamic and attempted to tailor the reciprocity according to the context of the situation. From the pilot project, I learned that listening to the respondents' stories and providing an opportunity for reflection was perceived as a valued experience and a benefit of participation. This benefit was reaffirmed in this study process. The opportunity to receive feedback and a final report was perceived as an additional benefit of participation. Respondents in turn voiced their gratitude for being given the opportunity to share their reflections and to support the research process and knowledge building.

Reporting the Data

The following chapter includes the findings of this study. This chapter depicts my constructions of the respondents' stories informed by the thick, rich detail of their reflections. The students' voices dominate this chapter as I have chosen to let their extensive excerpts "present adequate descriptive account" (Wolcott, 1994, p. 259). These reflections are reported in the contexts of emergent

categories, themes, and patterns of the data (see Table 2). This description in Chapter Three, conveyed through the students' voices, presents four vantage points from which to view these students' perceptions. These descriptive images will be further developed in Chapters Four and Five through analysis and interpretation to portray the shades and textures of the findings.

CHAPTER THREE

FINDINGS OF THE STUDY

Introduction

Geertz (1973) refers to people being "suspended in webs of significance" (p. 5) that they have spun. In the description of findings, I will attempt to depict these students' webs of significance related to care for older adults by presenting the students' reflections as they inform emergent categories, themes, and patterns based on respondent data.

During my interviews with students, I focused on obtaining their perceptions of how they have come to know and understand care for older adults. Our discussions included: the students' perspective on what care for an older adult meant to them, what was important to them in caring for older adults, how they believe they have come to know and understand care for older adults, and opportunities to tell their stories about powerful learning situations related to care for older adults (See General Interview Format: Appendix A). I conducted the review of documents with the same focus. Finally, I looked for similarities and differences in the students' verbal reflections and what was evident in the documents.

Meeting the Respondents

The respondents had all graduated from the same baccalaureate nursing program three weeks to three months previously. The respondents were all female, but their ages and backgrounds varied. Ages ranged from the early 20s to 40, and several students had degrees in another field. All respondents were from the Midwest, and one student had done some traveling in Europe prior to coming to nursing school. Although not a condition for respondent selection, in describing

themselves, all students had older adults in their extended families with whom they shared relationships.

The three students who were in their 20s were single. Megan had much early childhood experience with older adults associated with visiting dependent relatives in care facilities and meeting other older adults in those environments. Jody had much contact with her grandparents throughout her life including a close relationship with her great grandmother. Kim described her parents as "older." She was the youngest member of a large combined family that included many older adults. Kim also had work related experience associated with care of older adults prior to beginning her nursing education.

Four students were in their 30s. Leigh was single and related some experience with grandparents and an older aunt she visited occasionally. Margaret lived with a partner and related some early childhood experience with grandparents, but only had holiday-related connections at this point in her life. Margaret lived in the same city as her parents. Kirsten was married and had a family. She related early childhood experience with grandparents as well as recent experiences. Karen was also married and had children. She described her grandparents as very involved in her life and her children's lives. She also lived in the same community as her parents and grandparents.

Anne, who was in her 40s, was married and had children. She noted that she had three older women in her life that she was very close to: her aunt, her mother, and her mother-in-law. Further introduction of each of the respondents will unfold in the following description of categories, themes, and patterns of these students' reflections.

Description of Categories, Themes, and Patterns

Four themes were developed from the 39 categories or units of data that emerged from the students' reflections. These themes are: 1) Experience as a Growing Foundation, 2) Ways of Being, 3) Contexts of Care, and 4) Teaching and Learning Care for Older Adults. These themes are presented as four vantage points from which to view these students' perceptions. A photojournalist who seeks to tell a story with pictures works to capture the view from many angles. Each perspective adds a new dimension to the subject. Each vantage point captures nuances that convey the texture, depth, and wholeness of that subject. Such is my attempt at capturing the texture, depth, and wholeness of these students' perceptions of how they have come to know and understand care for older adults.

The first theme, Experience as a Growing Foundation, emerged from the types of experiences conveyed in the students' reflections. The second theme, Ways of Being, emerged from a "close up" framing of the students' discoveries of what is important to them as they interact with older adults. The Contexts of Care theme emerged as a backdrop or basis of the students' responses. The fourth theme, Teaching and Learning Care for Older Adults, emerged from my interpretive response to students' reflections as well as the documents they provided for this study. Excerpts from the students' narratives provide the composition elements for each theme by conveying perspectives and images that create the view from each vantage point. These themes are presented as the students' voices, in thick, rich detail, to immerse the reader in their perceptions. Themes will be summarized and further addressed in subsequent chapters for analysis and interpretation.

Theme: Experience as a Growing Foundation

The theme of Experience as a Growing Foundation includes eleven categories: (1) Experience / Opportunities in General, (2) Early Childhood Experience, (3) Role-modeling, (4) Experience that Nurtured Confidence, (5) Experiences Over Time, (6) Relating Experiences to Self and to Relatives, (7) Understanding Loss and Loneliness, (8) Dealing with Death and Grief, (9) Personal Feelings of Loss, (10) Experience that Shakes Confidence, and (11) Frustration. This theme emerged from the students' perceptions regarding the value of experience and the types of experiences conveyed in their reflections. In this theme reflections were viewed from the vantage point of the students' meaning-making of their experiences. Two patterns of viewing the composition of experience are depicted in this theme: (a) Experience to Support a Growing Foundation and (b) Experience to Challenge a Growing Foundation. The categories identified above will be described in one of these two patterns.

Experience to Support a Growing Foundation

Experience / Opportunities in General

Opportunity or experience in general with older adults was discussed as a foundation for approach to care.

> Anne: I think the opportunity to be exposed to older adults [is helpful]; to be involved with their lives in the clinical setting and the home health setting. I was able to be involved with [three families] that helped me reinforce the idea of the ability to endure the older years. Not just endure, but live through them and enjoy them. Just being involved with older people has given me the opportunity to define how I should go about dealing with them. The more opportunities you have to deal with older adults, or any segment of the population, the more you can evaluate how you behave and how you treat them; how you care for them.

> Kim: Everybody has different life experience and one person may not have as much exposure to the older adult [as another]. If they would walk into a

room and see a person that can't do much anymore, they don't realize what that person has done already in their life. There are other people who are more open and have experienced a great deal of things so [I think] they appreciate others more.

Kirsten: Having a lot of older adults as patients [has been helpful]...being around them more. As a nurse, especially now, with the aging population, most of our patients are older. Experience working with them helps out a lot.

Margaret: Life experience [has been helpful]. I guess that's what I brought to nursing too....what I brought to nursing is that life experience. As I learned to start caring for older adults, all those experiences came back to me.

Early Childhood Experience

Often during our interviews, the respondents used anecdotes from early childhood experiences with older adults to illustrate their responses. Although recollections from childhood were not specifically solicited, they seemed to provide memorable and significant foundations for relationships with older adults that also informed the student's life nursing education.

Megan: I spent so much time as a child and into my high school years in and out of hospitals and nursing homes....I lost my grandparents when I was young and then some older great aunts and uncles. I could relate to that population very well. I did not have a fear. We would go to visit my father's father in the nursing home. We would see him the first fifteen minutes and then we (Megan and her sister) would go to this lounge in the nursing home...and we'd just kind of sit and play and...they (the nursing home residents) would just start to talk to you....My dad said, "Talk to these people, they'll tell you stories...don't be afraid to talk to them and learn from them." I really valued the time I spent and what they had to say....I feel I relate more to (older adults)...that's where I feel comfortable.

Kim: I was always the youngest of all the family members whether it was cousins or sisters or even aunts. I was always the youngest and so everyone that was older than me I think I grew to respect. I think I grew from that experience of having all older people around me. And I preferred it that way. It was something I was comfortable with.

Kirsten: As children, my grandmother watched us all the time. They [mother

and grandmother] used to live next door to each other...we were real close with her.

Margaret: There are so many times that I have just sat with my grandmother and talked with her about what life means to her and to learn from her. I guess it's from that and just spending time [with them]...being next to them on a bench and not really saying much of anything...just being with them.

Karen: Grandparents are very involved in [my children's] lives on both sides of the family and I grew up in that kind of situation, of having grandparents around and living close.

Jody: I think it [referring to comfort in interaction with older adults] might have been the relationship my mom had with my grandma and grandpa...she was always wanting to go visit and then we were wanting to come along. Pretty soon mom would just be dropping us off...we'd spend the night with grandma and we'd do our nails or something. I really think that's where it all started from, just from being with my grandparents...just having to spend time with them. I think that if I wasn't exposed to that, I think I might be afraid of [older adults] a little bit.

Role Modeling

Student reflections included to both positive and negative role modeling experiences they had encountered.

Megan: There was a nurse that followed her [Sarah's grandmother living at home] for about a year or so....My grandmother had an infusiport and so [the nurse] would come by and do some of the medications. She would help my dad...he did a lot of the dressings, the changes and cleansing. She would come by and help him until he felt comfortable doing that. She would even stop by in the middle of the day. There was a tornado warning once and I remember her coming by to make sure that grandmother could get down the stairs because it was in the middle of the day and my parents were at work and my sister and I were at school. That nurse is the main reason that I decided to pursue nursing. I saw the effect she had on my grandmother and my family.

I can attribute a lot of [how I have come to know and understand care for older adults] to the way I was taught from my parents. They taught me respect for my elders but not like a formality. To really value the time that I have with those elders and to learn from them was very impressed upon me by my father; to take the time to listen because they have a lot to teach you about life, and you'll be a better person from it. That definitely shaped the

way I approach caring for an older adult...as a learning opportunity, as a learning experience...both professionally and personally.

Anne: I've learned to really respect other people who have a lot of respect for an older person; like our priest at church, the way he deals with the older people in the congregation. How they've set up a whole aisle of parking just for the older people at church so they'd be close to the door. I respect that and I tell him.

I've learned that it irritates me when people don't treat older adults with respect. I've learned that just by watching how I feel when I see older adults pushed around, not respected, not accepted, taken advantage of...watching how some people deal with them versus how I would deal with them or how I have dealt with them.

Kirsten: I see some nurses that don't really respect some older adult clients; especially like clients with dementia. They make fun of them related to their calling out. I just try to role model. I try not to follow along and do what they are doing...I try to treat them with respect. Some of the nurses call the older people little names, pet names...that really bugs me too. I try to be a role model and not call them by those pet names.

Karen: One situation that was really devastating for me was when they [the caregivers] all talked around the older adult and didn't acknowledge her at all. She was begging to be involved. She said, "Tell me what's happening," and they just ignored her. I felt so bad...they [caregivers] forget there's a person there...maybe it's because of some of the losses. She was hard of hearing and she kept asking and begging [to be informed]...she [the caregiver] was not addressing her. I really felt like she didn't respect her and maybe because she was an older adult it was more difficult to discuss things with her because she was hard of hearing but [the caregiver] didn't show her any dignity or respect.

Kim: [Regarding how she has developed her strong feelings about respecting older adults.] Probably just through exposure and the other side of that, watching people not care for older adults in a way that was more laissez faire; not thinking that they have anything to contribute or just seeing how other people can treat them in a non-respectful kind of way just shows how important it really is.

Experience that Nurtured Confidence

Students reflected upon certain experiences that had a profound impact on them as a result of what that experience gave to them. These experiences seemed to have in common a promotion of their confidence, an affirmation of them as caregivers, and allowed them to come away from the situation feeling "useful".

> Karen: My patient in [a particular nursing course] was very meaningful for me...maybe because of her circumstances. Being stricken with a deadly disease that was beyond her control. And then having the loss of her husband and her not feeling well. So I think what was the most meaningful to me was the importance of my coming [to see her] and her loneliness.
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> Megan: That's where I feel I do the most good...especially just taking the time to just sit with them and talk. I shouldn't generalize this to all of them, but some patients are very lonely. They've outlived their friends, their spouse, their family may be far away or have just kind of cut the ties, and I think they're much more appreciative of me taking the time to sit and explain something to them...or just taking the time to basically just sit with them and listen to them....I just feel best where I'm best serving my patients.
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> I got a letter maybe a month or two after she [a patient] had passed away. The letter was from her niece just thanking me for caring for her aunt like she was a member of my own family. That had a profound effect on me because I always kind of try to treat my clients and their families as if they were my family, or how I would expect and want my family to be treated....I smiled and I cried when I read that letter and I thought, you know, everything I worked for, this is the first time somebody had actually written this out and said this is what it meant to us...and it really meant a lot [to me]. I will never forget that moment...it's something that I keep in the forefront of my mind with each client I care for. This really did reinforce what I was trying to do...to say, "OK, I got something right."
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> Leigh: [Regarding an experience with a great aunt]...Talking about it with my sister she said, "I couldn't believe that you knew exactly what to do, how to help her to the bathroom. I would have been scared that she would have fallen,"....My sister recognized that I had learned a lot...that I knew what I was doing, that I was prepared to handle a situation...even as minor as helping someone to the bathroom...that affected me. I guess it made me proud of this profession I chose and I felt comfortable.
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> Jody: I think of one of my first clients; she was the first client I got to practice

many of my skills with. She trusted my judgment when I was just learning with her. She was listening to what I had to say; the blood pressure was alright but we found a lump in her throat and an extra heart sound....I walked away from there thinking I'll never forget her because she inspired my learning and my comfort level with that.

In school in Visiting Nurse Services, I had a client who was in her late 50s, she wasn't really older but she was mildly retarded and she needed a lot of assistance with a lot of things. I thought this was a powerful experience because I could see what a difference I could make just by teaching her prevention related to heart disease, which she was at risk for, and breast self exam. When I would come back that next week she would remember all the things [I had taught her]. I thought that was a good learning experience in that you can make a difference in a person's life if you take the time to get to know them. Prevention is the number one thing to good health and I made a difference in that. It gave me encouragement that it does make a difference what I do...I had never been able to practice that before in school... prevention, and basically I could go out and do it again because I had a good experience.

Experience Over Time

As the students discussed how they have come to know and understand care for older adults, their stories of experiences were the foundation of what they reflected upon. I was interested in the time span of these experiences as the students reflected upon coming to know older adults, and what that entailed.

Kim: I worked with a client, actually it was an older couple, and I worked with them in their home last semester. He was 78 and...had a stroke in '92. He wasn't able to move his left side very well. When he was younger he was active and held down a full-time job; now he was basically homebound. I had the opportunity to talk with him at least an hour a week for seven weeks. At first it was on the surface talk and then later on we got to talk a little more in depth. A couple of things triggered my thinking about how life is for the older person living in their home. It wasn't until after the fifth week that the trigger came out that he was just bored in his house.

I think from my experience, working with adults in their home on a one-to-one basis for several weeks is a good start [to come to know and understand care for older adults]. It's kind of hard at first to get to build rapport, but after that's done, you can discover how wonderful the elderly are on an individual basis.

Karen: [I visited this patient] a whole semester and then I continued to visit her the next semester...maybe 15 to 20 visits, and she's been in the hospital and I've visited her there too...I'd like to see her more often because she did make an impact on me.

Leigh: These were people that I saw pretty much on a daily basis...and just like any of us, moods change from day to day so what works one day doesn't work the next day, and that's a source of frustration, but you learn to deal with it and maybe go back to something that worked a week ago and hey, maybe it works again. Caring for an older adult month after month, you find out what works, what doesn't work, and you feel comfortable with each other. I think that it is invaluable; building that relationship over time...they know how you are going to react to them and how your are going to lead them through taking a shower or any other cares...and I know how they are going to react, I know what help they need.

Margaret: They can have an impact on you in a relatively short amount of time and you can learn a lot from it, but I don't think it's the same as going through time with somebody, where you experience all the different emotions, the frustrations, the anger, happiness, and joy with them...with Sandy, I don't think I would have come to know half of what I did if there had only been a few visits. I think the time span over an entire semester made a difference.

Relating Experience to Relatives and to Self

Experiences with older adults took on personal meaning as the students related experiences to their own lives. Students reflected upon their grandparents and other close relatives as they conveyed empathy for the care needs of older adults.

Karen: Some of [what is important related to care for older adults] I have learned from my grandparents...the loneliness. My grandmother struggles with loneliness...she doesn't want to move out of her home....and it's the same circumstance there [referring to Karen's 97 year old patient who is determined to stay in her own home]. We've encouraged her to maybe move to a place where she would still have control, could leave and drive her car but still would have people around her.... So maybe my understanding grew [based on my personal experience].

Megan: A patient that stands out to me I didn't have in school related clinical. She was somebody that we had on our unit [at work] and she had been in and out of the hospital for the last two or three years and then spent the last six months of her life in the hospital. We developed a very close knit relationship. Her niece was the one who took care of her...their relationship very much reminded me of a relationship I had with my great aunt, the closeness. Her niece called me to let me know she had passed away. I had said my good-byes to her before I left [my shift]...it was very emotional...this woman was just the greatest. She was spunky, very sarcastic; she had nicknames for all of us staff. She was just full of life. I left that day knowing that I would never forget her.

Leigh: I suppose with older adults, some of them take on grandparent characteristics. I can see my grandmother in a lot of these people, even the stubborn ones. I think grandmother would be just like that if she were in this place...I guess the fact that I only have a grandmother left, I respond to some of those people as grandparents. And I think they respond to me as grandchild...and that's fine. I've learned a lot about why my grandparents do the things that they do from [my nursing education].

Kirsten: I treat every elderly person as if it were a member of my family...my grandparents. I feel like I give them better care if I look at them as grandparents. I didn't always [think of them that way]. I think just because my grandparents are elderly now, I can relate to older adults better. I've had that exposure. I see a lot of similarities between my grandparents and elderly patients and their way of thinking....It's hard to see people growing old, like my grandmother who is 86. It's hard for me to see her in pain some days because she had arthritis. My grandmother is 86 years young. She is very independent. She had been taking care of her husband who had many physical problems for years and years, and he just recently died.

Kirsten related how she chose to do a pet therapy project as part of a class assignment. She chose to do this project for her grandparents before her grandfather died.

Kirsten: Now that I've gone through this I believe I'm more sensitive to pet therapy and the needs of people....I guess I would probably reflect back on my grandparents' situation and probably compare it to somebody I had been assigned to. It gives me a basis. I believe that this was a good thing for my grandparents as a couple; it made them closer and it gave them a common ground. A lot of times there was just so much stress in their lives that they didn't get along real well, but when the dog was around they got along fine....Right now the dog is [my grandmother's] life. We didn't know that my

grandpa was going to die within the next year....It [the pet] was the best thing for her.

Jody: I'm lucky to have spent the time that I have with both of my grandpas before they died; I got to know them. I know that both of them were alcoholics, and I saw what they went through as older adults...how they were dependent on alcohol and why. So that the next time I see someone like that, it helps me to be better able to understand why they became dependent on a drug...that alcohol thing...just being in that life experience. Being on that side helped me to understand their situation, if I do run into something like that [with a patient].

Margaret: Maybe it would be the same [having a fascination for wanting to know what it's like to grow older], if I had been close to my grandparents, like if my grandma was living with us or something. Maybe it would be the same or maybe there would be frustrations there too. I don't know. I don't have that so it's one of those things that I wonder about...what would it be like? It always makes me wonder, do they have that kind of care [her grandparents living in a retirement village in Arizona]?....Do people care about the fact that they are living?

Anne: I think that funding is a big issue for older adults...people's ability to pay for their care. It's just that some older adults don't know how to use the system to their advantage. My mother-in-law wouldn't go to the doctor...because the doctor she went to would not accept Medicare, so anything she needed done she would have to pay for out of pocket and she didn't feel she could afford it. She was getting sicker and sicker, so finally I overstepped my bounds and I called around and found another doctor that would accept Medicare. My husband asked me to do this. So I did that and then we approached her and told her this was done and she was very angry. As it turned out she was diagnosed with cancer and we were able to get treatment....It didn't cure her, but at least it has been paid for and she could get pain medication and treatment. I still can't believe that her other doctor wouldn't accept her Medicare payment.

The transfer of meaning became even more personal as the students' reflections conveyed thoughts about self and identifying directly with the older adults' experiences. Karen reflected upon her experience caring for a woman with AIDS and how her initial fear changed.

Karen: I was there maybe a couple of hours, maybe three at the most I

> guess, and I don't know what I was fearful about or what I expected to begin with exactly. I don't know why I was fearful, and I think what changed was that I could see she had feelings just like me and she had concerns. I could see her as a person, not just this disease. I could see all that she had been through and she had family like mine. I could see how important they were and the relationship they had with each other, so I guess I could relate to that.

Attempting to distinguish empathy in caring for any patient and the empathy that Karen was experiencing related to care for older adults she continued her reflection:

> Karen: I think that just coming to know their [older adults] circumstance and their life experiences and maybe relating that to my life...[the patient's] experiences with her family. She talked a lot about that and maybe looking at myself too in that relationship, the similarities and maybe differences. Understanding her life experiences and how much knowledge she has and coming to respect her for all of her life experiences that maybe I still have to experience. Maybe that is somewhat of a difference in caring for someone that is an older adult.

Other students spoke to directly relating to the aging process themselves. Megan spoke about things she can now relate to differently because she was identifying similarities between her grandparents and other older adults she has cared for but also:

> Megan: Because I'm aging too...I've had more life experiences and I can look back on those and I'm able to apply them to my work.

> Leigh: One of the issues that bothers me is Alzheimer's Disease; when people, especially people I know, get treatment for it...It's in my family....My grandmother had it, so maybe looking at that with my mother in the future possibly, and myself in the future....I guess it doesn't affect me to a great extent right now but it might in the future and I think about that.

> Anne: The fact that I'm getting closer to being an older person helps me be a little more open to it. I watch my husband; he's older than I am, he's graying, and he's starting to do things differently...slowing down. Even though we're just in our forties, we know we're changing and we're getting older and our kids are growing and getting ready to leave. I never thought

I'd be here. I don't know what happened to the last twenty years. But I'm more ready for it I think, because I know that these are the best years that are ahead of me.

Margaret: As I'm turning 30, I'm watching my own parents and looking at them a little differently. I haven't yet figured it out, how this fits into my own life. Like what choices am I going to make with my own parents? What kind of choices am I going to make about my grandmother or my grandfather? Because now that I know what it feels like with other people, it's easy to look at a family and say, "How could you do this?" But then you start thinking about what would it be like if I had them move into my own home? What would that mean making that kind of commitment or sacrifice? I haven't figured it out though, what I would do. I still struggle with that, and that's a direct result of caring for people; that you become aware of these issues and you have to think in your own life, what meaning does this have for me?...What am I going to do for myself, for my partner?...How am I going to cope with that?

Experience to Challenge a Growing Foundation

Understanding Loss and Loneliness

As students reflected upon powerful learning situations related to care of older adults, some also talked about coming to understand the losses and loneliness that some of their patients were experiencing.

Karen: I'm thinking of two cases in particular in school. One involved an older lady who was 97 years old and still living at home by herself. In both of these circumstances both of these people had had a lot of losses in their life...not only personal losses but physical losses too like eyesight, and physical dexterity, and hearing loss...extreme hearing loss. I think those losses are very hard. I don't think people understand that. And then these losses lead to depression. I think those are very important things to be concerned about when caring for someone that is older.

Sometimes I felt like the most important part of my visit was just talking about things, reminiscing about their lives, and the importance of discussing that. Maybe coming to terms that life may end soon and understanding that they've done some good things in life...they needed someone to discuss their thoughts with. They really had no one else to talk to.

Leigh: My great aunt was in a nursing home. All of her life she was very, very active, traveling a lot, never married, so very independent...just on the

go all of the time. The last time I visited her I helped her to the bathroom. I helped her too while she was in the bathroom. I just realized how frail she had become and it really had an impact on me personally. It made me realize just how important health is and how quickly you can lose it...it's nothing that you take for granted.

Kim: [Regarding her patient who had a stroke,]....It made me stop and think about depression with older clients and their activity level...no, they can't run around the block anymore, but just what activities can they do? I think more needs to be focused on the things they can do, so that they feel they have some control over their lives still and some meaning for their own life.

Jody: [Trust is important] because they don't have a very big support system...maybe their husband or wife has died and their kids live out of town...and they can't get out as much and can't go visit people...they are at a time of their life when they are losing people.

Margaret: [Issues for older adults include:] loneliness, isolation, sense of autonomy, loss of loved ones, physical changes such as menopause or just the whole physical body and how to deal with that, friendships, developing relationships, security, and what security is to people...wanting to empower people to feel like they have some control over who they are....Just being respectful of the different transitions people are going through.

Dealing with Death and Grief

Dealing with death and grief was associated with care for older adults for some of the respondents.

Kirsten: Maybe we as students need to be assigned clients that are dying. I think that would be a good thing. Actually being one-on-one with the dying patient; actually seeing what they are like when they are dying, and exposure to the common things that happen when they are dying. I think dying patients would have a better experience too.

A lot of older people have lost most of their friends and their spouses. They are kind of in a depressed state. It's hard to know how to deal with it...that might be another thing to focus on in class too...how to deal with grieving.

Margaret: Death and dying is a huge issue. Seeing that death is a life process, and learning to see that it can be a beautiful moment. Encouraging people to share with their loved ones...encouraging family members to be

> part of this. I think a big part of this is letting our children be a part of this process. I wish my parents, when my grandmother died, even though I was in college at the time, I really wish that my parents would have offered or maybe even demanded that we be there at her side instead of just mom and dad.
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> Anne: I think the first time I dealt with death of a family member [was a really powerful learning situation]. There's an aunt that I talked about previously regarding when her husband died of cancer. I think that was a real learning experience. To see how they dealt with that; how they, in their married lives of 42 years, dealt with that.

Anne also came back to this thought as she reflected upon what she liked least about care for older adults.

> "...dealing with death and life issues for the older adult."

I asked Anne to further elaborate on this topic of grief and care for older adults in our second interview.

> Anne: Perhaps it's a perception that I have of aging, that there has been time to look back over your life span and reevaluate how you have lived...and I would think most people would see things they would have done differently. In reevaluating, they probably had to go through a grief process in coming to terms with how they dealt with things or didn't deal with them. I think for the older population, they have had to deal with grief in losing friends, jobs, families, and their spouses; more so than any other population.

Personal Feelings of Loss

A few of the respondents related personally to feelings of loss associated with the death of older adults for whom they provided care.

> Megan: I don't know if there's anything that I really dislike about caring for older adults. I think one thing that comes to mind is that ultimately there's going to come a point were they pass away. You go through your own individual grieving process...that's probably the worst part.
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> Leigh: You tend to become attached to them. Deep down you realize that nobody lives forever, but you also become fond of them...it's hard to lose

them. I guess that's not any different than it would be with a child...that could be anyone really. I think you can get attached to people of all ages and mourn their loss because you were attached to them. But I think my experiences are mainly with older adults, so that's why it's easy for me to get attached to them; because that's who I care for more.

Experience that Shakes Confidence

Students reflected on their struggles with patients with dementia and other circumstances that caused them to feel powerless.

Margaret: [Regarding her patient with dementia,]...This was the first client I had to care for and when I was confronted with that, boy that was hard...really hard. Seeing her pain and thinking, "Is this what it's about because if this is what it's about I don't want to go there." Where is the joy in that kind of living? Being abused by the system and possibly being taken advantage of, and not having a sense of any power or having any rights over your own body. Being treated as an object in the institution where insurance dictates more about care than who one is as a person. The issues are endless that I was confronted with...that I didn't like at all and yet I had to develop a relationship with her in the midst of it all, and it was really challenging.

I think in some ways it had to do with wanting to take away the pain. Then coming to realize that Sandy had her own life and made her own choices in her life as well, and that's something you can't take away, you can't change that. I guess it's not about fixing the situation as much as just being with her and getting to know her. It might even be just helping her work through some stuff that she still has to work through. Being there for her to bounce things off of instead of going in and trying to change her life for her.

My whole purpose with Sandy was only to develop a relationship with her instead of understanding the dementia or the illness or anything like that from a nursing standpoint. I look at every aspect of one's life; the social, the psychological, the spiritual, the physical...I didn't have any of that going in to be with Sandy. In the end, having had Sandy, I think it challenged me at a level that I needed to be challenged. It was an issue I was wanting to deal with, wanting to work with the older adult; part of that was because it was a mystery to me.

Kim: I would say mental issues need to be focused on...the older adults' mental capabilities. I've really come to know that you need to focus on that greatly...as well as their physical side, but I think the physical side is usually the focus and the mental side needs to be focused on as well....There needs

> to be a balance there. By doing that you can try to reach them, to see if they are having depression, to see if they're having issues with death that you need to approach. That gets hard if the memory is an issue, especially like in an Alzheimer's situation.

Kirsten related a memorable situation which she had discussed earlier in reference to one of her patients dying.

> "... I felt powerless I guess, there wasn't anything I could do."

Leigh referred to this feeling of powerlessness also as she related an experience when her patient's condition suddenly changed and she struggled with knowing how to react in that situation.

> Leigh: It scared me...I thought, "OK, think back, what do you do when someone's having a stroke?" "I don't know, keep them comfortable." I didn't know what to do. So this is one of my favorite clients, and I thought, "Not here, not now."

Frustration

> Students reflected upon frustrations in caring for older adults.
>
> Megan: One issue that made an impression on me was elder abuse and neglect. Unfortunately we have seen a lot of patients coming in who have not received the appropriate care. I get so frustrated and disgusted when that situation arises.
>
> Kim: It's hard for the older adult that doesn't take care of themself, "I've been smoking for 26 years, why should I stop?"... "I've had a bad diet for years...why should I change now?" The same with exercising. I think that's really hard...they're set in their ways. It's hard if they don't want to change. It's hard for them to change and it's hard for you to find ways to get them to compromise a little. It's frustrating...I think that's the key word there, when you want to do something for somebody and they're not helping themselves and they're not doing it, it's very frustrating.
>
> Jody: [Older adults] can be a little frustrating at times because, it might sound bad, but they are slower, and sometimes you are in a hurry and they're not....They want to talk and you have two other people wanting you to help them with this or that, especially working in the hospital. It isn't their

fault but it is frustrating.

Margaret: The hardest part is patience...I have a tendency to go, go, go; I want to slow down. I wanted to take a walk with this woman who lived in her home. It took us an hour to get down to the front walk and back. I felt we were going three inches at a time. It's a love and hate at the same time. I saw so many details that I never would have seen walking with this woman down the front walk. You know, I would have done twenty blocks by that time. I think there's a need for patience in that I need to step back and a say, "OK, just be here and now with this person," and just be here now and don't think about anything but just walking with her, and being with her, and when I can do that it's great. When I can't do that I get very frustrated. That just comes with experience and my own mood. The same emotions would come up with Sandy where there would be that frustration of, "Come on, let's move," or when she didn't understand...I'd get frustrated.

This kind of goes back to the first time I had to take care of someone with dementia. It terrified me, absolutely terrified me...that was one of the first times my emotions started interfering with how I cared for somebody and just what that meant. The whole loss of the mind and Alzheimer's...how hard it was to be around that and the struggle that I went through. The pain I felt in my own emotions, and the frustration of not being able to have a conversation, and the exhaustion after being with her for an hour and realizing, my God, there are people out there that take care of these people on a 24 hour basis like a wife or a husband. I felt so drained. Then realizing that part of my fear was facing what that must be like to grow old and lose your mind. Then there was a transition phase in caring for Sandy where I sort of learned to back off and accept her for who she was and I didn't take on as much and it became easier for me to face my own fears and explore them; realizing the importance that as a caregiver you have to do that in order to begin to open up to the situation. I found that I was no longer frustrated but almost came away from the situation energized.

I also realized that caregivers need a lot of support and need a way of stepping away from that situation to gain perspective on how they feel, and the frustrations, and that their frustration is part of it. You still love this person, you're just having a really hard time dealing right now and maybe you don't have the support you need to care for this person. I guess that's where caregiver stress really becomes an issue.

Anne related a story about working with a couple in their home during a senior level nursing course. The husband was trying to care for his wife who was diagnosed with Alzheimer's disease.

> The husband was very frustrated and irritable and angry at what was happening to his wife...he was just a wreck. I spent a lot of my time caring for him rather that for her. I developed a relationship with these people. I went back to the organization I was working out of and talked to a staff member about the couple. She was just very upset and very irritable because these people had just worn her down. This man was so irritable and so angry and wanted so many services that she didn't have. I came away from that situation thinking, I wouldn't want to feel that way about these people...These people still need our care, still need our help, let's not give up on them. I know this staff person was working hard to do what she could within her parameters. So it was frustrating for her and she saw them and dealt with them a lot more than I did. I just thought, I don't want to get to this point where I give up on people out of frustration with them.

Summary

This theme: Experience as a Growing Foundation, depicts experiences the students reflected upon as they discussed how they have come to know and understand care for older adults. The theme details an array of experiences conveyed in these respondents' perceptions. Two patterns of viewing the composition of the range of experiences are depicted: (a) Experience to Support a Growing Foundation, and (b) Experience to Challenge a Growing Foundation. These patterns allude to developmental supports and challenges to the process of how students come to know and understand care for older adults. This theme of supports and challenges connotes both the significance of life experience and the broad range of experiences that students bring to bear on their developing perceptions.

Theme: Ways of Being

This theme includes fourteen categories that convey how the students reflect upon what they have discovered to be important to them in their interactions with older adults. These categories include: (1) Developing a Relationship,

(2) Getting to Know Them, (3) Making Connections, (4) Trying to Understand / Empathy, (5) Respect, (6) Patience, (7) Learning from the Individual, (8) Listening, (9) Enjoying Their Stories, (10) Acceptance, (11) Strength and Potential in Aging, (12) Advocacy, (13) Promotion of Independence and Autonomy, and (14) Recognizing Uniqueness of Needs.

In this theme two patterns emerged. The first pattern, (a) Ways of Being as a Means of Knowing the Older Adult, depicts one vantage point. This view focuses on facilitating sensitivity to the uniqueness of each older adult in the students' approach to nursing care. The second pattern, (b) Ways of Being as a Reflection of Esteem, is an end in itself. This second vantage point captures ways of being or behavior which the students perceived to be fundamentally important in their interactions with older adults. The categories identified above will be described in one of these two patterns.

Ways of Being as a Means of Knowing the Older Adult

Developing a Relationship

The importance of relationship building was expressed often as the students reflected upon how they have come to know and understand care for older adults.

> Jody: [What I like most about caring for older adults] would have to be the relationship if you develop it. You can't always do that, but when you can, it is rewarding. You need to spend time with them. You have to trust each other, and you have to be accountable to build that trust.
>
> Kim: Through a developed relationship you can accomplish a lot more than if you're just on the surface and not personal with them; they won't trust you.
>
> Megan: I think [what's important] is establishing a trusting relationship...a very open relationship where they feel that they can talk about whatever is on their mind...whatever concerns they have. Once you have established that you can feel that emotional bond, not just nurse-patient.
>
> Karen: [What is important to me is] to build that caring relationship so that

> they feel comfortable to share their feelings....For me [it's] to understand them and that they understand me, and to build that trusting relationship.

Karen also identified something she called reciprocal caring, which she noted in particular with one story of a patient care situation.

> Karen: I think we made an impact on each other. I cared about her, she cared about me...I still think about her and what's happening in her life. I've been to see her since then and she remembers me. We made an impact of each other's life...caring about each other.

Margaret focused on two older adult patients whom she refers to throughout the interviews.

> Margaret: ....They got under my skin. ["How did this happen?"] I guess just allowing myself to be open to their pain and their joys, their feelings and emotions; forming that relationship with them and not being afraid to go there with them. Being able to cry with them and to laugh. I guess it's sometimes being able to experience pain with people; you can learn from it in the same way that you can with joyous moments. I think a big part of it is when you let someone affect you that way, it's about letting them inside and sharing a part of yourself as well as taking on some of them, not in an unhealthy way. It's more of a mutual exchange that the energy flows and you gain a lot from it.

Getting to Know Them

Knowing the individual was important to the students as they reflected upon care for older adults. That this "knowing" was multidimensional was evident in the student responses.

> Megan: I don't think you can provide adequate care...unless you have a base of knowing where they are at. [Here Megan is referring to documents brought to the interview that reflected how she went about collecting the information that provided her the "base of knowing" she speaks of.]

> Anne: You can't care for them if you don't know who they are. I think knowing the people is what's important in providing care for them...getting to know them and letting them know you. I think that means a lot to them; that

you are willing to share with them too.

> Kirsten: What I like most about caring for older adults is talking with them, getting to know them, building that rapport, and having the feeling that they trust me and like me. A lot of times I'll have something in common with them and I'll share that with them. Finding out their background, who they are, what their needs are, and what they feel their needs are so we can get a general consensus of those needs.

> Jody: Take the time to talk with them without just starting right in and taking their blood pressure. Maybe the first visit just sit down and talk with them and find out who they are and start to develop that trust and the accountability.

Jody elaborated on what she meant by "finding out who they are"...

> Jody: You have to get their perspective on how they are feeling and about their life... what they think they need, what they are scared of, what they enjoy, what they like, and what makes them happy. It's getting their perspective on their health and what they think they need. It's getting to know their likes and dislikes, their fears...it's basically having a friendship.

Karen also referred to "knowing" her patients. She discussed how she felt she was more sensitive to the needs of older adults and others' lack of respect for those needs as a result of "coming to know" two patients in particular.

> Karen: [I'm] definitely more sensitive because of coming to know these two people [patients that Karen referred to throughout the interviews] and their feelings and their fears, and their need to feel independent and to care for themselves, and have a mind and express themselves just like everybody else even though they might not be quite as capable as they used to be.

From Karen's esthetic project reflections she wrote:

> I also feel I have personally gotten to know Helen. I can tell when she is not feeling well or when she is tired...I now understand that getting to know my patients will be the biggest help I will have in deciding what my patient needs are. By establishing a personal relationship with my patient I will be able to understand them, to be able to care for them better.

Kim explained how she was drawn to certain patients at an adult day-care facility

where she worked before coming to nursing school and how she reached out to them.

> Kim: In the beginning I just worked with them but then I could kind of pinpoint some of the individuals that some of the staff weren't focusing on as much as I thought they should be. So I reached out to them a little bit more and found out more about their personality and their experiences and got to know them a little bit deeper. I found out about some of the things that they wanted to do, and through that time and communication I got to know more deeply about those people.

Enjoying Their Stories (Listening to Know Them)

Students also reflected on the importance of listening to the older adults' stories. These were perceived as not only enjoyable but an important means of getting to know the individual.

> Anne: [What is important in caring for an older adult is] having time to be present with them. I think it's important to be able to share time with older people...that they would be able to share their past with me so that I could bring their history into my caring for them; their past, their history, their stories, and what's important to them. Sometime down the road, if something happened to them that I was dealing with, something critical or major in their life, I could understand where they're coming from because I...understand their past.

> Leigh: I like to listen to their stories. I like to talk with them and know what they did when they were younger. I [took care] of one lady I never would have imagined was a basketball coach. You don't think about what they did in the past...they were people back then too. I do like that and I wish I had more time to just sit and talk with them...it would be good therapy for everybody.

> Kirsten: It seems like when I talk to them, I can figure out what's important in their lives by their stories. You can find out a lot about them through their past. [That's important because] it's easier to relate to them. You get to know them so that they trust you. You build rapport and trust.

Listening

> Kirsten: Something happened just recently as I was working as a health care technician on a surgical floor. We had a lady of Spanish background

who had had surgery and she was doing fine. One day when I was taking care of her though, she was not feeling well at all. She complained of not being able to catch her breath. She was just generally feeling that she was doomed...I was working with a nurse and we were thinking she was having problems with her medication but later that day she died. That was very forceful. I guess what I learned from that was to really listen to the patient and to take them very seriously and to look at all the alternatives that could be happening. She was older too. I went home and I couldn't sleep for a couple of days after that. I got out my books and I thought what else could I have done...I guess just to listen to the patient.

Leigh: I think in nursing we are so busy that it's hard to take that extra couple of minutes to let someone know that you really are listening to what they're saying. You just have to listen to people and really hear what they say.

Trying to Understand / Empathizing

Kim: I try to understand what life is like to [older adults], what it was like for them, and empathize with them so you can figure out what they want, not what you want to do for them.

Karen: I didn't understand the need for [Helen] to reminisce. You know both of (my patients) were working toward the end of their life within a short time; basically because of Helen's disease process and Ina was old, she was 97. Sometimes I think that when Helen was talking to me about her life I maybe didn't look at this as a need for her to do that as much as I did with Ina. I think I probably changed as far as looking at the importance [for them] to communicate about their life. Not that I didn't think that was important with Helen. Maybe I really didn't understand the importance of her reminiscing about her life and I could see that a lot in a different view with Ina. My views changed on understanding the need for that.

Karen talked about how these two people caused her to have a new

understanding.

I think maybe because they were able to express their feelings about their losses, they were both able to feel bad...depressed about their losses. In both situations they cried about it...so I guess coming to understand their feelings [made a difference] for me to understand their feelings.

Karen made the following comments in a final project document:

> My interventions changed from what I thought was important, to what I found was important to Ina. What I believe was most important to her was presence, understanding, respect, trust, and communication. I was present for her to talk about anything she wished. I tried to provide her with empathy and understanding. What she needed most was a good listener and a compassionate friend. She needed someone to share her life experiences and express her life's self worth.
>
> I believe that I built a helping-trusting relationship with Ina. I came to understand what she values in life. She values being seen as a person, not just a patient. She values being able to do things for herself and an environment that permits her independence.

Karen also talked about how she changed in her view of her patient with AIDS.

> Well, one thing in particular was that I learned to look beyond her disease process, to see her as a person, and I think that was a big step for me because sometimes it is easy to just look at the person, who in this particular situation has AIDS, and see that person only in that sense. And that's how I walked into her house, that's the only thing I was thinking about, and then left the very first day thinking totally different. This is a person...not a person with AIDs, this is a person that I really care about.

Karen reiterated these comments in an esthetic project summary she brought to the interview.

> I feel like I have a good perception of what it feels like to be a person with AIDS. I feel like I have gained a good perception of what it feels like to be lonely.

Anne spoke of coming to understand some older adults' experience of multiplicity of loss and the grief that can be associated with that.

> Anne: ...That's part of their history. You need to understand that part of their past. If you are working with a twenty year old, they think nothing bad can ever happen to them. They will have a different perspective than someone who has lived longer. [Older adults] are more realistic. They realize that yes, I could die, yes, my spouse could die, everything is not necessarily going to turn out OK. So there are fears that you are dealing with when you are caring for them, ultimatums and decisions, will it be better if we do it this way or that way?

> Leigh: You really are understanding the pain that they are feeling, not the physical pain, but the emotional pain. That's something that I've consciously worked on developing and I'm having to work on it.

Margaret spoke about a cardiac patient and her husband that she cared for in nursing school. She spoke of trying to understand what this experience meant for the couple.

> Margaret: [The patient] was really neat, she was wonderful. I loved her and her husband. When you're around that [kind of situation] you really get a sense of what it's like. You've lived your life with someone for so many years and then there is that fear of losing them during cardiac surgery; for this woman it was triple bypass surgery. The pain in her husband's eyes, just the thought of what a major thing this was, and the effect on their marriage and their relationship. It's not just about caring for the heart. It's taking care of their emotional needs too, and especially if she's the main caregiver around the house...doing all the cooking and cleaning around the house, and she won't be able to do a lot of that when she goes home...it will change the dynamic of their relationship.

Margaret spoke of another experience where she gained empathy for a 91 year old woman who was living alone in her home.

> Margaret: Something happened in [a community-based nursing course] that I had never really thought about before. Part of me has always feared nursing homes; I never really wanted to think about having to live in one or having to put somebody in one. But this just happened to be a situation where I thought having your own home would be a great thing. The woman I visited was 91 and living alone at home. Basically her home had become her prison. She could barely move. She didn't have any family left. She didn't have any children, she didn't have any family, I mean nobody...and she lived alone in her house.
>
> When you go into that situation you think, "Wow!" She loved having a nursing student she didn't even know come to see her once a week for an hour. Her excitement and her energy...we're talking about people here that have their minds still. She would laugh and be so witty. Her mind is still there; and yet she has no one to share it with...and a society that maybe doesn't even know that she exists....Neighbors that maybe will help take care of her lawn but maybe won't walk with her on a daily basis. That was hard. And I remember my instructor and I and several students sitting around a table and coming to that realization that wow, you think about

someone having their own home as having everything, and then you begin to realize that it's about needing people around you for support; wanting to have someone around you to share. I guess that whole concept really impacted me. It made me more aware of the depth of need...

Making Connections

Margaret: I think of a walk I took with someone who was in San Sebastian, Spain...he was much older than me, he could barely walk. He had an umbrella and I didn't so I shared it with him as we were walking down the block. I didn't have any idea who this person was so I said, "Have you always lived here?" He said he had. I said, "So you don't want to see the world?" It was just amazing to me because he didn't. He said, "Why would I want to leave? Everything I want is right here." I thought, wow, that's a concept. I hadn't thought about it like that. When I came home from Spain I used that quote a lot. I met this man for five minutes and he impacted me. I came away having been changed in a way by that experience. I think about that a lot.

Karen: I walked in there [the patient's home] with this huge fear...and then left. Well it took me a few days after to really put things together, to understand what I was really feeling. By the next time I went I wasn't looking at her as a person with AIDS, but as someone I really cared about and wanted to get to know.

Kim: I think they [older adults] are fun to work with. One of my favorite clients is a grumpy old man. If you can connect with him, then all of a sudden he is talking about everything in his entire life and you just kind of know that you made that connection and that feels really good...just to get to know them...I just enjoy that...[it's a challenge] to find the spark.

Kim continued to talk about a specific memorable care situation with this older adult.

He was just a great guy to go in to talk with. I kind of cared for his wife as well. You see with a couple that has been married for 60 years, you have to work with both of them because they are kind of one unit...they work together. You need to find ways for both of them to improve their health and reach both of them rather than just one person. It was just a great experience working with him. He was an excellent client...he was a challenging grumpy old man.

Kirsten: A lot of times I'll have something in common with them and I'll share that with them...I had a lady in the hospital a few weeks ago and she had two cats. I really didn't have a close relationship with this lady until I found out she had two cats and I have two cats, and so we talked a lot about our cats and we really got close...I had never seen a smile until she talked about the cats.

Ways of Being as a Reflection of Esteem

For several of the students, the question "What does care for an older adult mean to you?" generated thoughts about how to be with older adults rather than what to do for and with them in the caregiving role. These reflections seemed to convey ways of being with older adults as an end in itself. The responses focused on qualities of (1) recognizing the uniqueness of needs, (2) respect, (3) patience, (4) being open to learning, (5) acceptance, (6) seeing the potential and strength in aging, (7) being committed to promoting independence and autonomy, and (8) advocacy. Student thoughts on these qualities follow.

Recognizing the Uniqueness of Needs

Megan: I think care for an older adult means taking care of them in the hospital and also in the home setting. It's meeting all their needs, physical and physiological, and also caring for their emotional and spiritual needs.

Leigh: It means identifying that older adults have different health care needs than say someone my own age or a pediatric patient. Once I've identified those needs it's determining the best way to go about addressing those needs.

Jody: [Older adults] have many needs. It's important emotionally and physically to have someone there to help them. I think gaining experience with older adults in school or with my family, just talking with them, helps you to get to know them and their needs, and that these needs are all related. All older adults are individuals with special needs.

Respect

Anne: I think [care for an older adult] means respect for the older adult. Realization of where they come from..not just seeing who they are now but who they were.

Kim: I think [care for an older adult] should be honest and respectful. I think respectful would be the key word there. I've worked a great deal with elderly people and they've lived very fulfilling lives. I think people need to respect that more and can learn from them more...just by talking and listening to them. Society in general doesn't respect older adults enough. They are still purposeful...they can still contribute to our society and they have contributed to our society. We need to appreciate and respect what they have founded for our society as well...[we must] definitely respect them.

Karen: I think [care for an older adult] means giving them respect. I think that as people age they feel like they've lost a lot of their independence and maybe respect, and I feel that it's giving them that respect and promoting their independence.

In one particular situation I was with another person [nurse preceptor] I was working with in a managed care situation, and instead of talking to the older adult, she talked to the caregiver at home, and the older adult was very interested in wanting to hear for herself. She was hard of hearing and she kept asking and begging, and it just broke my heart that she was not being addressed. She was capable of caring for herself to some extent. But I feel like [the nurse] didn't respect her and maybe because she was an older adult it was more difficult to discuss things with her because she was hard of hearing, but [the nurse] didn't show her any dignity or respect.

Margaret: Respect them, or revere them...come to know where they are and their issues and their struggles that they go through...There seems to be a sense of commitment and responsibility for caring for the older adults that I saw in Spain that I don't see here so much. The respect that I saw for the elderly is what I don't see here so much....These are people too and life doesn't end when you're sixteen...it goes on. Sometimes I wonder if we aren't a little backwards here in the United States because of the fact that we put so much emphasis on youth and younger children, and we forget about our grandparents and the people who have gone before us.

Patience

Leigh: I guess being patient enough to take the time to care completely about the complaints that they have and the symptoms that they're having,

and realizing that a lot of the physical symptoms older adults experience are psychological in nature and are due to a grieving process...a loss. I deal with that in-home care. I will just be chit-chatting with people and find out that their best friend died and they're just about the only one left in their little circle....Just taking the time and being patient is something that I've had to work on. I'm not a patient person.

Kim: Just being patient and taking the time to get to know their true personalities [is what has been the most helpful in coming to know and understand care for older adults]. It's kind of hard to know that on the first meeting when you talk to them. So it's taking the time to work with them. It takes a lot of time and patience to reach these people to honestly discuss with you what's on their mind.

Jody: You need the right people to care for older adults. It takes someone who has patience and understands what they are going through....They need that relationship for their mental health and building trust with them. It's just that they're older, and maybe they can't hear you, and they're slower, and you have to help them to the bathroom...they may want to stop and tell you stories and you have got to listen, you can't just say, "No, I've got to go, there are other patients waiting for me." You can't do that...you're ruining that trust and that relationship if you do that.

Learning from the Individual

Karen: They have so much knowledge or lived experience to share with me...maybe that's why I enjoy them so much. She [a patient] was always giving me advice, not in a motheriy sense but...encouraging me too...about the importance of family...she would go on and on about that, and she gave me advice from her years of experience. That maybe is partly why that had so much meaning for me.

Kirsten: I think [older adults] have a lot to share and we can learn from them. If we just keep our minds open and listen to them we can learn a lot. Respect their opinions. If you don't agree with their opinion in a particular situation, determine why they have it.

Margaret: You know, when you are caring for an older adult there is something different than caring for a younger child. They have been through life. There is something different there, even though the issues may be the same. Basically everything I have said here could relate to a child or a younger adult, but when you are caring for an older adult and there is a sense that they have lived 40, 50, 90 years, and when you think about that,

that doesn't come with youth; it only comes with age. Just realizing I have so much to learn from them and they have so much to give...you have so much to learn from anyone you care for.

Kim: You can learn about how their life events changed them and some of the experience that they have had you can learn from. Sometimes you can say, "Well they experienced that so maybe I'll make my decision this way"...in relation to care decisions and personal things too. Just being open is really important; just having an open mind and being open to all the possibilities that the older person has to offer.

Acceptance

Students reflected upon their learning to accept thinking different from their own and the importance of this in caring for older adults.

Margaret: Sometimes it's realizing that what's important here is not necessarily that they do what you are about or what you think is right or wrong. It's about the relationship you develop with them and accepting them for who they are and even if they are different, enjoying those differences. It's not about changing them, but accepting who they are, and not imposing your values on them, that's just who they are. They are not going to be different than they are comfortable with. You just have to learn that [each] generation is very different and you just have to respect the choices they made....Sometimes it's difficult for me to respect the choices that they made [referring to some of her family members], but that's all part of it. You have to know who you are as a person when you are caring for someone. You need to be secure with that and see people the way they are.

Anne: [Regarding what care for an older adult means to her.] It's accepting them for who they are, rather than expecting them to be who I think they should be...and allowing them to be, and not to try to make them fit into a box.

Anne related her experience with watching her aunt and uncle struggle with decision-making when her uncle was dealing with a terminal cancer diagnosis, and then how this influenced her support of her parents when they had a similar experience during her father's diagnosis and cancer treatment.

Anne: Caring for them in that situation was a real learning experience. It made me realize that I had to accept them for who they were and accept the

> decisions. Because I'd learned from watching my aunt and uncle, I was able to be a lot more supportive of my parents than my sister and my brother were....I was able to support them...accept their decisions, not expect them to do what I thought they should do and not judge them for their decisions that they made.

This learning experience transferred to a patient care experience when Anne was caring for a man who was diagnosed with cancer. She was able to work with the man and his family within the context of many emotions that existed.

> Anne: There was a lot of stress...you could feel the tension in the room. You could see the pain. The wife wanted to help him. He was angry he was dying. She didn't know what to do, and the aunt and uncle, the sister, they were wondering what they could do to help. It was a very emotional time for the whole family and I as a student was able to support them, be nonjudgemental, and realize that they were struggling with these decisions that only they could come up with the answer for. They just had to work through it and get to the other side. It was better to be supportive than to jump in and tell them what I thought they should be doing.

Recognizing Strength and Potential in Aging

The students' reflections conveyed different ways of thinking about aging and changing abilities.

> Margaret: Do you remember when Calvin Klein or maybe it was J. Crew started advertising using older models? It had a huge impact on me that life does not end [as we age]. There's just so much to look forward to. I've learned just how much power and knowledge we as nurses have to help people understand that there can be a lot of strength in growing older or getting weaker in some respects. [Aging] doesn't have to be seen as a bad thing. Perhaps it's letting go of an old way of thinking about yourself. Right now my partner is having a hard time letting go of that youth concept...why don't I feel the same as I did when I was 25, and what does that mean? It's learning to think about yourself differently. I think that goes back to our society's emphasis on youth and how we value that, and the whole beauty concept and boy, it's not often that you perceive an elderly person's body as beautiful. That's why I started liking those ads, because they started to see aging people for who they are. In this way it helps with the concept of the changes in your mind. You can see that the beauty is there...it's just different than what we have been conditioned to think it is.

Anne discussed an article she brought to the interview that she felt had a particular impact on how she has come to know and understand care for older adults.

> Anne: This article is about women that are strong and that the things that make them strong are a contradiction. The realization that older women can be strong and are capable, even in the face of death of their spouse, their children, loss of home, loss of youth, and loss of health, they can still be strong and face it and get through it. The article interviews different women about where they found their strength and all the things that are available; it's about relationships with other people and being able to have courage to progress through the difficulties of life. It's possible for every person to achieve that and it's not anything magical that you're going to have to do to be strong. That was very enlightening for me...to realize that these women, just because they are over 65, it doesn't mean that they need to be in a nursing home or need to have around the clock care. They are very capable and they could be capable for 30 more years or more. When I read this article in my first year of nursing school, that was a whole new idea for me. I always imagined that my mother would eventually be totally dependent on me. I mean, my father is gone and she is still going. She has appreciated my change in attitude.

Promotion of Independence and Autonomy

> Kim: I think that sometimes you want to care for older adults and you want to do things for them, but you realize that you can't just "do" things for them. You have to find ways to help them help themselves. Maybe start them on the path with references and people they can contact. By doing that you can help them have some control in their life and their health care. In that way they feel they are taking care of themselves; they have more of a sense of accomplishment....I think independence is a big thing [to older adults]....I think a lot of people want to do things for older adults. "It would just be easier to just do it for them." Some people don't think that older adults can take care of themselves or respect them enough to [promote older adults' independence].

Kim reflected on a patient care situation she experienced in nursing school that exemplified her respecting this individual's needs.

> Kim: I worked with a client...he was 78. He had a stroke in '92 and he wasn't able to move his left side well. When he was younger he was rather active and held down a full time job and now he was basically home-bound...he was just bored in his house... so we focused on things he could

do rather than on what he couldn't do.

Karen also referred to two patient care situations in which she focused on promoting their dignity even though they had experienced losses.

> Karen: Some people don't give older adults the respect, and trust, and independence to care for themselves. You don't need to come in and take over all of their care because they are capable of doing some things, even though they have some losses. For Helen that was a big thing for her...she still wanted to live in her home. I remember suggesting to her, "Wouldn't you be so much happier in another place?"....Not necessarily that she couldn't do for herself, but not in her home where she is by herself all day long. She was insistent upon her staying in her own home until she could not do it any longer. That was a big deal for her. She wanted to stay in her home...she didn't want to go somewhere else even though she was lonely.

Margaret spoke about how maintaining the older adult's dignity and autonomy is different than care for a younger person:

> Margaret: If anything, I think I take a little bit more time in how I approach that relationship. There's a lot to learn from this situation and this person. This is a full grown person who has been making decisions for a long time and their own choices, who now might be in a very healthy situation and might not be used to having to surrender to the medical community, or to surrender their own autonomy. So just remember these are people like ourselves, who at one time had their autonomy, or have been making decisions for themselves all their lives, and it still is very important to them...helping them to maintain that dignity and respect. That's just different than when you are caring for a younger adult.

> Kirsten: I think it's important to assist them but yet I think we need to promote independence; where they can go on with their life like they did before they entered the hospital. It's fun to see them progress and go home.

Megan talked about coming across an idea that made her see things differently than she had before.

> Megan: ...the whole concept of health promotion and prevention. I guess I had a preset idea that as people age and as they have various complications with health, they just take a laid back approach to [recovery]...not very active, not going to return to optimal level of health at that point. The whole idea of health promotion is thinking it's never too late

to prevent further complications regardless of their age. You want them to return to a level of health that fits them and their circumstances as optimal. That really made me think about my attitudes and how I looked at making my [care] plans appear and my interventions...they weren't so much focused on treating the disease process...it was more improving their mental attitude and the physical nature to getting them up on their feet and getting their momentum back.

I think it started in the sophomore level [of nursing school] and I applied it more my junior year when I was in my medical surgical rotation. The majority of the patients were above the age of 70. I had a pneumonia patient and maybe a congestive heart failure patient...to see that they could go home and function well again...that it didn't have to diminish their life. Temporarily it does, but they can still return to that level of functioning that they're used to. It was nice to be able to implement this more, and do a lot of teaching, and a lot of education for them.

Megan talked about how this thinking has influenced how she considers the potential older adults have within the community.

Megan: I think getting older adults involved in community activities [is important]. I go to the wellness center and there are many older adults that go there and walk on the treadmill, and do the water aerobics, and ride the stationary bikes. It's so nice to see that somebody is out there encouraging them to do that. So when I am in my daily work, I try to impress that upon them, to get out there and get involved. There's senior citizens' centers and the congregate meal sites that help with the social activities. You don't just have to stop, you don't have to be isolated, you can get involved. That's what I really try to work on... connecting them with social services and helping find that match that's going to be good for them.

Advocacy

Kirsten: I think caring for an older adult means showing them respect...being their advocate.

Megan: [Older adults] view you as somebody who truly does care...a friend to help them out and to answer questions, and somebody who's going to stand up for them.

Megan used an example that she felt really brought this point home to her.

Megan: The main thing I see in my current work situation on a cardiac

floor is that most of our patients are 60 or over, and lately we have had a stretch that we have had most of the patients on the floor in the upper 70s and 80s on up. It is reinforced each day I am at work ...I see how important it is to be a patient advocate. This was magnified with a patient I had just a few weeks ago. Her own requests were being ignored...the physician said, "She needs to go to a skilled facility," and the daughter said, "OK," and this patient, no one is asking her...she was being ignored. I was working the night shift and I walked by her room and she was crying. She said, "I'm not going to a skilled facility, I know what they are talking about but they don't talk to me. I'm not going to a skilled facility." That just really reiterated the situation for me. I wasn't going to be around in the morning when the physician made rounds but I made a point of talking to the next nurse coming on in the morning who fortunately was understanding, and willing to address this, and was willing to try to get this resolved.

This really brought everything together...how in caring for the older adult you really need to be the advocate for them. You really need to talk to them and not just go with what the family's requests, are or what the physician is saying. This was a patient who at times would be confused. It's not unusual you know for someone who is older to be confused in the hospital. Generally she was extremely oriented and was insistent that she didn't want to go to a skilled facility and yet no one was picking up on that. So we resolved it and she ended up going home with a home care nurse coming in to check on her a couple of times a week to just see how she was doing. I felt very good once that was all resolved. I can see this kind of thing happening on a daily basis and it just reinforces how important this is in the care for an older adult. A lot of times the psychosocial care is more important than the physical aspects of their care.

Summary

This theme: Ways of Being, depicts ways of being with older adults that the students' reflected upon as they discussed how they have come to know and understand care for these individuals. The theme itself details two different vantage points for "ways of being" in reference to care for older adults. The first vantage point was a pattern of ways of being as a means to the end of coming to know and understand older adults. This was a way to individualize the approach to nursing care for them. This pattern reflected ways of getting to know the individual

through the development of relationships. In this way of being, students conveyed their need to pursue an in-depth focus on the individual to seek the subtleties of the uniqueness of that person, to know and understand them better.

The second vantage point was a pattern of ways of being as an end in itself. This way of being was a reflection of how students perceived they should "be" with older adults rather than what they should "do" for and with them in the caregiving role. These perceptions suggested a way of being that conveyed regard or esteem for the older adult. Here students appreciated the texture of the fiber of the individual, and took a "macro-view" to acknowledge the breadth of who the individual was, and is, and can be.

Theme: Contexts of Care

The theme of Context of Care includes seven categories: (1) Family, (2) Life, (3) School, (4) Hospital, (5) Community, (6) Work, and (7) Nursing Home / Retirement Center. This theme emerged from the circumstances or conditions that were the origin of the students' reflections. In this theme student reflections were viewed from the vantage point of the context of their responses rather than the content. Many of the examples were reflections that have been introduced in the earlier themes (See Themes: Experience as a Growing Foundation and Ways of Being).

Family

All students made reference to family or family experiences as the context of many of their reflections even though family reference in the initial questioning was unsolicited. Family context was historical in some sense in that many examples the students used were from their past.

Many students reflected upon relating to older adults based on their

experience with grandparents. Jody related the relationship her mother had with her grandparents and how this led to Jody and her sister spending much time with grandparents.

> Jody: I love talking to my great grandma. She's 97 and we can carry on this great conversation. I've never been afraid to approach her. My other great grandma lived with my grandma and we'd always go over there to eat. We'd always talk and they would always have stories. I enjoy that the most...their stories. I think that's where it all started from, just from being with my grandparents and having to spend time with them.
>
> Megan: The first four years I was in school I lost a grandparent each year and then some older great aunts and uncles. I spent so much time as a child and into my high school years sitting in the halls of hospitals and nursing homes; that pretty constant exposure to older adults, and never feeling threatened, awkward, or uncomfortable in that situation really set my attitudes and opinions, and really continued through school. Little old people would wheel out with their wheelchairs and start talking to me...and I just sat and listened and learned. Part of it is I can kind of see bits and pieces of my grandparents [in older adults] or maybe try to fill in some of the void that I felt growing up without grandparents.
>
> Leigh: Some [older adults] take on grandparent characteristics [to me]. I can see my grandmother in a lot of these people, even the stubborn ones. I think grandmother would be just like that if she were in this place...and I guess the fact that I only have a grandmother left, I respond to some of those people as grandparents. And I think they respond to me as grandchild...and that's fine.

Leigh also related an experience that involved a resuscitation decision-making issue related to a patient of hers with Alzheimer's Disease. Leigh identified with this situation as she noted that Alzheimer's Disease is in her family and she felt this decision could arise with her grandmother, her mother or possibly herself in the future.

> Kirsten: Respect [older adults'] opinions. If you don't agree with their opinion in a particular situation, determine why they have it. I'm thinking of my grandmother when I say that...she's real opinionated.
>
> It's hard to see people grow old...like my grandmother who is 86. It's

> hard for me to see her in pain some days because she has arthritis. As children she watched us all the time...we're real close. She helps me start my garden every year...she feels needed....She has a good relationship with [my children] too. They like to go over and see her and stay all night once in a while.
>
> I think because my grandparents are elderly now I can relate to older adults better...I've had that exposure. I see a lot of similarities between my grandparents and elderly patients and their way of thinking.

Kirsten related an experience she had in which she developed a pet therapy project in school that she chose to implement with her grandparents.

> Kirsten: Now that I've gone through this I believe I'm more sensitive to pet therapy needs of people. I guess I would probably reflect back on my grandparent's situation and probably compare it to somebody I had been assigned to [as a nursing student]. It gives me a basis.
>
> Margaret: I can relate to my grandparents and the relationships. There are so many times I have just sat with my grandmother and talked with her about what life means to her and to learn from her.

Karen's family reference was more recent as she discussed her grandmother's current struggle with loneliness.

> Karen: [Regarding what she has learned that is important to her in caring for older adults.] Some of that I learned from my grandparents...the loneliness. My grandmother struggles with loneliness even though she is capable of being with her friends. I know she still struggles with loneliness. I have learned that sometimes the people closest in their lives, like my mother helping her out, they are the hardest on...so you kind of put yourself in that position...as you visit people in their homes. You need to remember that sometimes they are the hardest on their caregivers. That is one thing that may help in my role as a nurse. They may be the sweetest people to the nurses but they may be very difficult on the people doing the daily caregiving.

Karen saw herself using this experience to help her relate as a caregiver and...

> ...even explaining it to someone else. Like my grandmother, everyone thinks that she is just the neatest lady in the world, not that she isn't, but sometimes she puts the guilt trip on you "You haven't been to see me in weeks...I know

> you're very busy, but you haven't been to see me in weeks. You haven't called. I'm so lonely." You feel really bad but I don't know that if I came to visit her every day it would make her happy.

Karen also talked about her grandmother as she reflected on coming to a deeper understanding regarding older adults' need to remain independent.

> ...I have a grandmother who doesn't want to move out of her home. She would not move out of her home. She will have a nurse come and stay in her home before she will move. It's the same circumstance [as an earlier example of a patient struggling to stay in her home]. We've encouraged her to maybe move to a place where she would still have control...could leave and drive her car, but still could have people around her to play cards with. So maybe here my understanding grew.

Additional reflections dealt with other older adults in the respondents' families. In her discussion about a powerful learning situation related to care for older adults, Leigh made reference to helping her great aunt while visiting her in a nursing home. Leigh came to realize how frail this favorite aunt had become and related this awareness to her thinking about some of her patients.

> Leigh:....I've had several home care clients that were my favorites, and one day they seem fine, and the next day they've just taken a turn for the worst and they're in the hospital and they maybe don't come home. You tend to become attached to them and deep down realize that nobody lives forever.

Kim reflected upon how working with older adults has always been a focus of hers.

> Kim: My family background would have a great deal to do with it I think since I was always the youngest of all the family members whether it was cousins or sisters or aunts. I think I grew from that experience, having all older people around me. I preferred it that way. It was something I was comfortable with.

Anne referred to her experience in dealing with terminal illness with her uncle,

father, and mother-in-law. Anne identified each of these experiences as powerful learning situations that taught her to support these individuals in their decision-making, their need to remain in control, and for some, their death.

Life

The context for some of the students' reflections was simply life experience in general. Anne related how irritated she becomes when she is aware of circumstances in which older adults are not treated with respect. Out of this increasing awareness she believes she has gained a sensitivity for those who do convey respect for older adults.

Margaret related similar thoughts as she compared the sense of commitment and responsibility for caring for older adults that she had witnessed in Spain with what she sees as missing here in this country. Margaret gave her perception of a different pace needed to care for older adults:

> Margaret: You need to slow down your own life and be OK with that for awhile....It's one of the greatest gifts. In some ways I wish my life were more like that....I remember the old men in Spain sitting on the bench. That's all they would do all day long was just sit on the bench...I would sit with these men and talk with them...Boy that's a different life than we live but man they saw things that I never took the time to see. They never missed a sunset or sunrise...they took the time...they had the time. When we're younger we're caught up in our careers, and life, and the pace is just so much faster.
>
> Kim: I feel like I've had a lot of exposure to older adults. That's always been my focus in school and life. I like working with them more than children. That's always been my focus for nursing...it's just because that's me.

School

Nursing school was the context of some of the students' reflections although this vantage point was more detached. Although fewer specific examples were included, it was a reflection on what these respondents perceived nursing

education had to offer in general.

Megan discussed the role her nursing education played for her in reference to her coming to know and understand care for older adults. Megan perceived that her family experience, related to care of her grandparents and great aunts and uncles, was focused primarily on meeting psycho-social-spiritual needs. School added a new dimension.

> Megan: I picked up care for the physical needs here in school when we started clinicals as we learned baseline assessments and all the skills we learned with caring for an older adult. In school is where I learned to tie the three together. I finally was able to care for the whole person: the mind, the body, and the spirit. School tied all the strings together.

(The assessments Megan referred to were documents completed and included in nursing care plans and brought as a sample document for this study.)

> Karen: [Regarding what has been most helpful in coming to know and understand care for older adults,]...just being exposed to situations and getting to know older adults. I've had exposure to grandparents that are still living, but when you are put in a care situation as in school...caring for them is different than knowing them as grandparents. I do have fairly healthy grandparents...I sometimes forget their ages because my grandmother is still driving around...she is 87. It helps being exposed to someone with health problems like the 97 year old lady that I talked about...she was doing really well and still living at home.

> Kirsten: I think my education did a really good job of preparing us for caring for older adults because we did have a class devoted to it. But that hands on care, you can't replace that. That's not something you can find in a book. The empathy is something you can't express in a book either. I think that maybe needs to be focused on a little bit more...getting to know the patient.

> Leigh: I think in my work a lot of my assessment skills and things like that come from my school experience. I wouldn't pick up on subtle changes...if I hadn't had the school-based experience. Outside of grandparents, I think I learned a lot about why my grandparents do the things that they do from [the sophomore level nursing classes]. One of the things I remember learning about was how older people manifest disease symptoms differently than younger adults. What really sticks out in my mind is [what I learned about]

urinary tract infections. Symptoms in older adults may be different from those experienced by someone my age and subtle cues are what you have to look for. It's something that I wouldn't have known had I not had that class.

Hospital

Reflections within the context of care for older adults in a hospital setting seldom were school related and conveyed both positive and negative images. Generally "lack of time" to get to know the patient and develop a relationship with them seemed to be an issue in the hospital context.

Margaret related a patient care experience that involved a cardiac patient and her husband. She remembered seeing the pain in the husband's eyes and trying to understand the effect this bypass surgery would have on their relationship as a couple. Margaret's analysis was that this couple's emotional needs were as important as the acute care of the heart.

Anne: In an institutional setting you have so many responsibilities in a 12 hour period. You have to get everything done and the way it is now, you have more patients than you have time to care for in the way that you would like to. Even in an ICU setting you may have one or two patients, but you still don't have time to care for them by spending the time to get to know them...that's on the bottom of the list of responsibilities which is unfortunate.

Jody reflected on how much she enjoyed spending time talking to older adults and that this is what helps her to enjoy caring for them. However, when questioned about how she manages to do that in her nurse's aid job in the hospital she conveyed some concern.

Jody: Well right now, being a nurse tech [a nurse aid position], I have a little bit more time than the nurses do...especially with role redesign. We are paired up with a nurse and have the same patients so we are able to spend more time with them. Hopefully that will help too when I am a nurse since I will have [a nurse tech]. You have got to make time and I think that's what is so frustrating now because the nurses don't have time.

Leigh: [Regarding her experience working on a hospital cardiac floor]...so

> you don't have that time to build the rapport and develop the relationship like you need to do with these older adults who need continual care week after week, month after month...
>
> I work on a cardiac floor so [code versus no code] is an issue. I have fully become convinced that people know when they're going to die and then prepare for it...you just have to take the time to listen to people and really hear what they say.

Kim talked about how attitudes toward people can be conveyed during a change of shift report in the hospital.

> Kim: Just be open to people. If you're in a hospital and you hear during [change of shift] report that this person does this or this person does that...[I think] fine, it just may be a different reaction to a different person. You need to just go in there with an open mind and see how that person responds to you.

> Kirsten: As a sophomore, we had clinical in the skilled care unit at a hospital and I don't think I had a very good experience there. I think that's why I didn't want to go into gerontology.
>
> I feel like some of the older adults on our floor need more one on one care and we can't really give them that so they might be ignored a little more than some of the...younger persons... on the floor.

Kirsten related how she felt that some of the nurses she worked with in the hospital did not respect some patients, especially those who were confused. She felt she needed to role model respectful behavior with the hope of changing others' behavior with these patients.

Karen related an experience in which she was working with a staff person who was ignoring an older adult patient's requests to be informed of the circumstances of her care. Karen perceived that because this patient was hearing impaired and posed a communication challenge, the caregiver chose to ignore her requests for information. Karen related that this overt display of disrespect broke her heart. Similarly, Margaret discussed how increasingly she sees the need for advocating for her older adult patients in the hospital in which she currently works.

She related how patient requests are ignored and that she has had to function in the role of patient advocate to assure that patient wishes are respected.

Community

Reflections within the context of care for older adults in a community setting are provided in this category. An attempt was made to separate nursing school-based community context and other community experiences. It was noted that all reflections except one were nursing school-based situations.

> Kim: I think working with adults in their home on a one-to-one basis for several weeks is a good start [to help students to come to know and understand care for older adults]. It's kind of hard at first to get to build that rapport but after that's done, people then can discover how wonderful the elderly are on an individual basis....[Their home] is their own environment and you have less intrusion. They feel more comfortable in their own home...I think people are more themselves in their own home. From that (perspective) you can explore the environment they live in and people feel more comfortable with talking to you as well.

> Jody: For older adults, you need to see their environment...and see if there are any difficulties there. [In community nursing] I think I could make more of a difference, I could spend more time with them...
> [Regarding a care situation with an older adult that Jody will never forget,]
> ...She was the first client I got to practice many of my skills with...she trusted my judgment when I was just learning with her....She loved the company of me coming there to do these things.

> Megan: In my community health rotation I saw strictly older population patients. I had two females, I believe one was about 70 and the other was in her 80s. Both of them lived alone. Both of them were isolated from their families and were considered home-bound. One of them had a lot of arthritic complications. She had terrible knees and could barely get around. She left the door unlocked as she couldn't get up to let us in. The other woman was just the opposite. She could go here and there but she was losing her eyesight and wasn't allowed to drive and really didn't get out much unless someone would come and take her out to dinner. I used functional health pattern assessments to give me a firm understanding of were they were at with every aspect of their care and that helped me to focus in on maybe three or four key ...goals that I wanted to work on with them. I saw one patient for maybe five or six weeks, then we would switch off and I took care

> of the other for about five or six seeks. I could really pick out with those assessments how to care for these patients.
>
> Anne: I think the opportunity of going to family practice or home health or community health [is good]. You have the time to go into the home and know the people in their life setting...know what makes them tick...[this] is more important than giving their medication every four hours or taking their vitals. That's important, but you're not getting to know the people and you can't care for them if you don't know who they are.
>
> I think the home care setting is more advantageous for care of the older adult. They're more comfortable in their home...I think maybe you would have more time with them...hopefully having the time to get to know them...I think more so in the home health setting.

Margaret described previously her semester long experience with Sandy, a patient with dementia, who lived in a retirement center and had no family involved with her. She also described a 91 year old woman who was living alone at home. Margaret's reflections were a result of my request to tell me about a time when she came away from a care situation with an older adult thinking, "I'm never going to forget this situation because..."

> Margaret: Because they got under my skin. I guess just by allowing myself to be open to their pain and their joys, their feelings and emotions. It was forming that relationship with them and not being afraid to go there with them.

When asked to reflect upon a really powerful learning situation that she had had in or out of school related to care for older adults, Karen discussed two cases in particular which were associated with school assignments and also involved patients in a community setting. Both patients had experienced multiple losses including both personal and physical changes. Karen talked about the meaning of these two situations to her in terms of how she now thinks about loss.

> Karen: You understand their feelings about their losses, not just the physical losses, but sometimes the importance of that is overlooked. Caring for Helen was very meaningful for me...maybe because of her circumstances.

> Being stricken with a deadly disease that was beyond her control. Then having the loss of her husband and her not feeling well. I think what was most meaningful to me was the importance of my coming [to see her] and her loneliness.

Karen talked about the sensitivity she gained through these two care experiences.

> Karen: Sometimes I felt like the most important part of my visit was just talking about things and reminiscing about their lives and the importance of discussing that. Yes, [I'm] definitely more sensitive because of coming to know those two people and their feelings, and their fears, and their need to feel independent, and their need to care for themselves, and have a mind and express themselves just like everybody else, even though they might not be quite as capable as they used to be.

Work

Students also reflected upon their work experience as context for some of their responses.

> Leigh: I guess I've learned a lot about caring for older adults not only in school but in working Home Health Care. Things that I've learned, especially in home care, is that most people, even though they're old, still have a wonderful sense of humor. Humor is something that I use with a lot of my patients....I think I used that in some of my clinical experiences here in school. The experiences that you have with them, I think that's the best learning tool. Not reading books. Certainly that doesn't do it. The personal experience is what does it.

Leigh referred to a discussion we had after our first interview in which I questioned her regarding what I sensed was lack of comfort during our discussion.

> Leigh: I'm glad that after the interview we talked about what was making me uncomfortable. I think I was searching for things in school that, I guess I thought that's what you were looking for. When you clarified that that's not what you were looking for, that you were looking for any experiences...then that made me feel a little bit better....It's just that Home Care is where I've had the most exposure to the older adult, so I've learned what things work and what things don't work by trial and error...everybody's different....There is a lot that I learned in school that I think I couldn't have gone out and worked Home Care and done it effectively had I not had the foundation from school. However, I do think my experiences from the Home Care clients

were the first experiences that came to mind. These were people that I saw pretty much on a daily basis...and learned a lot about their history, and about their family dynamics, and took a lot from what they told me and put that to use in how I cared for them.

Margaret: I came to nursing school with five years of experience working at a family planning clinic and a big part of that was the last three years being in the education department. The whole five years I was working with people of all ages. [In relation to care for older adults]...I think a lot of our society think that elderly people can't enjoy sex which I find so sad. [I think] we didn't talk about that in nursing school, that whole concept to sexuality, other than assessing genitalia and that kind of thing. It's something that most students are not that comfortable with.

Kim: I worked at an adult day care...that was at the beginning of my nursing education....I was still going through the prerequisites but I hadn't taken any of the clinicals yet. Twenty to thirty adults came in and there were four staff that were there from 8 to 3:30 every day. The majority [of the patients] had Alzheimer's Disease or a stroke. There were also some individuals with mental illness. Respite care was a lot of it. Families needed a break during the day so they brought their family member in...even husbands and wives. I worked there about four months before I moved here. A lot of [my experience] reaches back to those [work] experiences.

Nursing Home / Retirement Center

Leigh's response to my request to discuss a care situation with an older adult thinking "I'm never going to forget this situation because," sparked a reflection about an experience she had working in a nursing home. Leigh was preparing to accompany a patient to the dining room. This particular patient informed Leigh that she was having a "TNT"...

Leigh: and I said, "A TIA?" [Transient Ischemic Attack] and she said, " Yes." I said, "Well, I don't know that people generally know that they're having those." I said, "Do you want to go to supper?" and she said, "Yes, I think I can make it." So I took her to supper and was sitting in the lobby where I wait for her to eat and another lady came up to me and said, "She's very, very sick." I went back to her table, she was in a wheelchair, slumped over. She was gray and drooling and she couldn't hold up her head....I took her back to her room and she started to come out of it. I called her family (and asked), "Do you want her to go to the hospital?" and her son-in-law

> screamed at me over the phone and said, "She's faking it." I now fully believe she was having a TIA and I'll never forget those symptoms. If I had it to do over again, I would have called the ambulance, sent her and then called the son-in-law. I guess if someone tells me they think they are having a TIA I would be inclined to believe them now....This was one of my favorite clients so, I thought, "Not here, not now." I was extremely bothered by (the family)....The whole family dynamic...it's part of what you have to deal with because the children sometimes become the parents when the parent can't completely take care of themselves anymore...so the children take on a different role.

Megan referred to issues of elder abuse and neglect and her increasing awareness of patients being admitted to the hospital who obviously have not received appropriate care. She noted these scenarios included patient admitted from their homes as well as those admitted from nursing homes.

> Karen: [Also referring to issues,]...the nursing home situation...I just feel like they are so neglected, just lying there. I did wound care for part of a nursing school experience. I followed a lady who works for a home health care agency. She is an ET [Enterostomal Therapy or wound care] nurse. We went to several patients to do wound care....One situation in particular I can think of was a patient who had an accident and maybe it had just happened, but there she was lying there all curled up. She wasn't very responsive, but still it was just was so pitiful for her, lying there in her own waste.

> Margaret related a new way she came to think about nursing homes:

> Margaret: Well what hit me was, what if nursing homes are a way for people to be around other people? It made me think about my grandparents living in Arizona in a retirement community and how much support they get from being in that kind of environment. They love it, they absolutely love it. They are able to do activities that they are interested in with a generation that is their age. They are very active. They play golf and my grandma runs. They are more active than I am. My grandma I know is in better physical shape than I am...I don't know if they would be doing that if they were still home, confined to their TV and not knowing their neighbors.

Summary

This theme depicts the context of the students' perceptions of how they have come to know and understand care for older adults. The categories are not self-exclusive as there is a blending of discussion of school-based and out-of-school conditions that create the composition for the students' lived experience. The variety of categories represent a range of possibilities of circumstances that have been the background for the students' perceptions including family, life, school, hospital, community, work, and nursing home / retirement center. I noted that reflections on family provided the most out-of-school context while reflections on community situations provided the most in-school context.

Theme: Teaching and Learning Care for Older Adults

This theme includes three categories: (1) Relationship Building, (2) Value of Early Childhood, Family, and Life Experiences, and (3) Making Meaning. This theme emerged from the specific respondent perceptions that offered thoughts and suggestions regarding teaching and learning. In addition, I revisited the respondents' narratives in the previous three emergent themes to draw out possibilities related to curricular design and / or teaching and learning relevant to care for older adults. This review of the previous three themes focused attention on: the significance of experiences that challenge and support the students' development, the notable context of those experiences being family and community, and the importance students placed on ways of being with older adults that reflected relationship building and conveying respect. These aspects as well as the reflections that follow contributed to the emergent categories in this theme.

Relationship Building

All respondents reflected upon the various opportunities that they have had, or wished that they had to develop relationships with older adults.

> Jody: I did have that foundation [with older adults] when I was younger...but [in my nursing education] we've been exposed to a lot of things. In [a beginning nursing course] we had to build a relationship with an older adult and in [a more advanced course] I feel like I was exposed to [care for older adults] and I'm thankful for that. Just seeing the different areas that you would have to care for them....My education gave me lots of those opportunities.
>
> [I enjoy most] developing the relationship [with older adults], if you develop it, and you can't always do that, but when you can develop it, it is rewarding....In caring for their physical and emotional needs, it's hard to do much when you don't have a relationship there...spending time with them kind of pulls it all together. [A relationship means] you have to get their perspective on how they are feeling and about their life. What do they think they need? What are they scared of and what do they enjoy? What do they like, what makes them happy, and getting their perspective on their health and what they think they need.

> Megan: I learned more [about care for older adults by] dealing with the families. I think it would have been nice to learn more about [dealing with the families]...but I don't necessarily think you always have those chances [in school]....[What's important in caring for an older adult] is establishing a trusting relationship...a very open relationship where they feel they can talk about whatever's on their mind and whatever concerns they have.

> Leigh: I like to listen to their stories, I like to talk with them and knowing..."Did you work when you were younger and what did you do?" That's so enjoyable. I do like that and I wish I had more time to sit and talk with [older adults].

> Kim: The one thing that I haven't learned in school, that I have learned through other life experiences, is the life of an older adult in a nursing home...to understand what it is like for an older adult to live in a nursing home with several others, usually with a schedule...what is their lived experience?
>
> I think that sometimes you want to care for older adults by doing things for them and you have to realize that you can't just do things for them...you have to find ways to help them help themselves.
>
> [What's important in caring for an older adult] is to establish a

personal relationship...when you are caring for them medically, try to create a balance...take the time to get to know them personally. Through a developed relationship you can accomplish a lot more than if you are just on the surface and not personal with them; they won't trust you.

Karen: What's important in caring for an older adult is to build that caring relationship so that they feel comfortable to share their feelings...and for me to understand them and they understand me and to build that trusting relationship...the reciprocal caring for each other, the understanding and the communication.

Anne: I think that to be able to share time with older people, that they would be able to share their past with me so that I could bring their history into my caring for them, their past, their history, their stories, what's important to them. So that sometime down the road, if something happened to them that I was dealing with, something critical or major in their life, I could understand where they're coming from because I know their past. I think that in nursing now there's no time to spend with people, unfortunately.

Kirsten: What I like most is talking with them, getting to know them and building that rapport. It seems like when I talk to them you can figure out what's important in their lives by their stories...you can find out a lot about their past. If you could talk to the patient and to the family members, you can kind of get to know what their life is like at home. Care for an older adult means finding out their background, who they are, what their needs are, what they feel their needs are so we can get a general consensus.

Margaret: I think I [have learned] to take a little bit more time in how I approach the relationship [with an older adult]. There's a lot to learn from this situation and this person.

Clearly the students valued relationship building in coming to know and understand care for older adults. The students conveyed their thoughts about the usefulness of this relationship as a foundation from which to sensitively individualize care for the patient.

Value of Early Childhood ,Family, and Life Experiences

Childhood, family, and other life experiences were a common reference the respondents reflected upon. The "Family" category in the Context of Care theme

included reflections by all respondents (See Context of Care theme description). These reflections conveyed the foundation these family life experiences provided for the students as they approached their nursing education. In addition, the pattern: Experiences to Support a Growing Foundation in the first theme included many examples of childhood and family life experiences that provided a familiar framework to which the respondents could relate. All categories in this pattern included reflections on childhood, family, and life experiences that the students readily drew upon in their perceptions of how they have come to know and understand care for older adults (See Experience as a Growing Foundation theme description). These out-of-school experiences were a significant resource for respondent reflections.

Margaret in particular offered thoughts about the value of contact with older adults early in an individual's life span as a foundation for social responsibility.

> Margaret: It would help if we exposed younger people to caring for elderly. It would be easier if we had our grandparents living with us. There's no reason why young children age 3, 4, or 5 can't be brought into what it's like to be around elderly people. Maybe it can start with just being aware of your own neighborhood or community. I'm just thinking of one patient in a community-nursing class; this woman's biggest concern was how to get the garbage out to the curb on Fridays. [Maybe we should be] helping children get hooked up with a neighbor person, where maybe you tell your son or daughter to put in some community service or they do some yard work for them or take the garbage out on Fridays. There are a lot of things we can do to involve young children such as elementary school age children where they can go get their paper in the morning before they go to school or drop off a donut, just little connections where you help your kids be aware of needs.

In reviewing the earlier themes I was aware that the respondents consistently drew upon many and varied life experiences as a foundation for their learning to know and understand care for older adults. These experiences

included early childhood experience with relatives and this circumstance was often noted to be connected with their present comfort (or lack of) with older adults. Experiences also included role modeling, confidence building, experiences with which the student could personally identify, as well as sources of feelings of powerlessness and frustration. The multiple references to these many and varied life experiences reflect their significance.

Making Meaning

The documents that the respondents provided included journal entries from a semester's coursework in two nursing courses, a care plan that was created for a patient over the span of several weeks, a creative project, a community final project, two esthetic projects, and two research articles that were significant to one of the respondents. Although the content of these documents was incorporated throughout the description of the other themes, respondent explanation of their choice of the submitted documents are as follows:

Karen discussed her esthetic project (an assignment early in her nursing education) and her final community project. She tried to summarize the meaning of these two pieces had for her:

> Karen: I think I probably changed as far as looking at the importance for [the patients] to communicate about their life...my views changed on understanding the need for that.

From Karen's esthetic project reflections:

> Through this project I wanted everyone to understand how much I have received from this experience...I went to give but took so much more from (being with my patient)...I soon found out that she was not just a diagnosis but a person I really enjoyed, and the issue of her having AIDS did not matter to me anymore.

From Karen's community project reflections:

> I feel that I had two new insights from my experiences with [the patient]. I believe that I actually knew both of these things but through [the patient], it was reinforced by new understanding of their importance.

Anne discussed two articles she brought to the interview. The first article focused on older women and their strength despite multiple losses. Anne acknowledged this article stimulated her transformational thinking related to the potential of older women in general and her mother in particular.

> [Regarding the second article on older women's stories of being strong]...I read through [this article] and I found what I needed for class and I thought, "This was really good, I'm going to keep this article and refer to it"...and I have throughout the last couple of years. I've read it again and again and picked up more ideas from it.

Kirsten explained the significance of a pet therapy creative project she completed with her grandparents. She discussed the needs that the pet she chose for her grandparents met including a reason to live longer for her grandfather, diversion from caregiver stress for her grandmother, and unconditional love and affection for both of them. She noted that as a result of this experience she is more sensitive to these needs for in others.

Megan discussed the nursing care plans that she created over a semester for a woman in her 80s. (Megan brought these documents for me to review.) This woman lived alone, was isolated from her family, and was considered "home bound."

> So these documents reflect the critical thought process that goes into caring for older adults...helping to establish a baseline to work from...and then from there, sitting down and working with them on what was most important...talking with them about what was most important to them in their lives that they wanted to work on. We would work on goals together...we would set short term and long term goals together...based on their ability.

Margaret's journaling and esthetic project reflections regarding her patient

care experience with a dementia patient named Sandy included these thoughts:

> It's not about taking on or away [Sandy's] pain or making her remember her past. It's not about probing her with philosophical questions or for stories she cannot remember. No, it's about living in the moment, fear or not. And having courage to face one's own emotions. It's about being "exquisitely present" to not only see the details that so often are overlooked, but to recall a time when I too was seeing the world for the first time as a child. When I hold a child's hand and walk through the park, I too live this experience, just as I am living it with Sandy...
>
> When [the speaker from Hospice] spoke of Alzheimer's and how it can affect people, not only the person with the disease, but the caregiver as well; it opened the door for me to accept my feelings toward Sandy.
>
> Gaut brings up a good point when she refers to how one chooses to word something. I think of my own feelings towards Sandy. I went in feeling like I was there to care for her. That in turn led me to feel I needed to do something about her situation, that I was responsible. As Gaut states though, "Caring about eliminates the apathy, indifference, obligation, withdrawal, isolation, manipulation, and possession in one-way relationships of caring for in the limited sense of providing for" (p. 316). I feel a sense of relief having changed my perspective on this.

Reflecting on the meaning of a clinical practice situation in a hospital setting,

Margaret wrote:

> This nursing situation taught me a lot, especially because this time around the family was involved, unlike in past situations where I have followed clients down to the Lab. I am much more aware now of how the family can get lost in the cracks and forgotten and yet how important it is for them to know what is going on along the way even if their loved one is just waiting in another room.

Another reflection from Margaret on a different patient situation:

> I really loved spending time with Molly that day. She brought home for me, once again, concerns that our elderly clients face that are so different than the rest of the population. Issues of loneliness, isolation, embarrassment, and loss of loved ones....Her situation also reminded me of the importance of human dignity and how one must never forget to check with the client before

one makes the agenda for the day. I thought she would be worried about her heart, when in reality, it was her bowels [that was her immediate concern]!

Summary

This theme depicts the many and varied learning means the students have utilized in their coming to know and understand care for older adults. The categories of (1) Relationship Building, (2) Value of Early Childhood, Family, and Life Experience, and (3) Making Meaning, depict the commonalities in reflections throughout the respondent interviews and within the documents that were provided for review. These categories underscore the value given to relationship building as well as the value of out-of-school experience in the learning process. The meaning-making category reflected a variety of teaching / learning techniques. The commonality in this variety of assignments was the students' reflection on the meaning this experience had for them and how this experience has caused them to see things differently and / or more clearly.

This chapter of findings is a framework created from the categories of data depicted in the respondents' descriptions. This framework has been presented as thick, rich detail of the students' perceptions of how they have come to know and understand care for older adults. This chapter has been presented as the students' voices with the organization of these perceptions creating the emergent themes.

In Chapter Four I will analyze the findings that have just been described and summarized. The emergent themes and patterns will be discussed integrating ideas from theory and literature in related fields. Chapter Five will draw upon this analysis as a basis for my interpretations and recommendations for nursing education and curriculum design.

CHAPTER FOUR

ANALYSIS OF THE FINDINGS

Introduction

In Chapter Three, the results of the study were described and summarized through emergent themes. The four themes: 1) Experience as a Growing Foundation, 2) Ways of Being, 3) Contexts of Care, and 4) Teaching and Learning Care for Older Adults, were presented through rich narrative detail of the students' perceptions of how they have come to know and understand care for older adults. In this chapter, the themes are analyzed in light of the research questions presented in Chapter Two. Findings are also analyzed according to previous research / theory derived from literature in related fields. Similarities and differences in the findings will be discussed through the integration of ideas from the literature. The chapter concludes with a summary of the analysis.

Analysis of Themes

The research questions to be considered in this analysis are as follows:

1. How do baccalaureate nursing students come to know and understand care for older adults?
    a. What is the significance of caregiving context related to the students' coming to know and understand care for older adults?
    b. What role does life experience play in the students' coming to know and understand care for older adults?
    c. What role does relationship building play in the students' coming to know and understand care for older adults?
2. Based on the nature of perceptions and existing literature, what teaching methods / tools might best nurture baccalaureate nursing students' coming to know

and understand care for older adults?

The emergent themes were discovered to correspond with the three defining sub-questions included with the first research question, which was: How do baccalaureate nursing students come to know and understand care for older adults? The four themes: 1) Experience as a Growing Foundation, 2) Ways of Being, 3) Contexts of Care, and 4) Teaching and Learning Care for Older Adults, will be analyzed in light of these research questions. In working with the emergent themes during analysis of the findings, I discovered that Contexts of Care and Experience as a Growing Foundation were closely linked. As a result of this discovered connection, the sequence of presentation of the themes was changed to facilitate the unfolding analysis of findings. The analysis of Contexts of Care and Experience as a Growing Foundation will be followed by analysis of the Ways of Being and Teaching and Learning Care for Older Adults themes.

Theme: Contexts of Care

This theme depicts the context of the respondents' reflections. Students' reflections were viewed from the perspective of the circumstances, conditions, or setting for the reflection. The question of how these students have come to know and understand care caused me to consider not only the significance of the "how" and "what" of the process, but also the "where". Although this theme is closely linked to experience, an effort was specifically made to attend not to what the experience entailed but where the experience transpired.

The variety of settings that were the basis for the respondents' reflections represent a wide range of conditions. The categories (family, life in general, school, hospital, community, work, nursing home / retirement center) are not mutually exclusive as there is a blending of discussion of school-based and out-of-

school circumstances that provided the backdrop for the students' lived experiences. Consistent with the wide range of experiences that the students reflected upon, the conditions also represent many different aspects of the students' life as opposed to only school-based situations.

Learning in Context

Wilson (1993) discussed learning and knowing as integrally and inherently situated in the everyday world of human activity. He suggested that context is not only an important element in thinking about human learning, it is perhaps central to understanding adult cognition: "In the situated view, experience becomes activity and takes on a much more dynamic relation to learning. Adults no longer learn from experience, they learn in it, as they act in situations and are acted upon by situations" (p.75). "If learning and knowing are to be based on the actual cognitive practices of humans, then they have to be located in authentic activity" (p.77). Regarding this idea of authentic activity, Wilson (1993) explained that it requires that learning and knowing always be located in the actual situations of their creation and use, not the simulations artificially constructed in schooling practices. "Thus, learning and knowing are a process of enculturation, not simply a matter of acquisition" (p.77).

Wilson's point regarding enculturation is an important one. Both out-of-school and in-school experiences the students reflected upon seemed to serve a socialization process. Out-of-school experiences were primarily associated with family and many of those were early childhood experiences. These students were being enculturated regarding ways of being with older adults at a very early age. Additionally, out-of-school situations included work experience. Students referred to past and present jobs and the meaning these experiences had for them related

to care for older adults. In-school experiences that were discussed were primarily associated with older adults in community settings. Did this in-school experience in a community setting allow for more authentic activity related to care for older adults?

Kuh (1995), and Lewis and Williams (1994) speak to experiential learning, the role of out-of-class experience, and adult learners' previous experience being associated with personal development and the need to adapt to a rapidly changing world. These authors suggest that because the nature of work is changing so radically and rapidly, a paradigm shift from a training to a learning emphasis is essential so that people are equipped to deal with new, unspecified challenges. Because of these changes, the authors believe it is important to implement experiential designs that encourage individuals to become continuous learners, to extract meaning from their experiences, and to pass the learning along in collaborative contexts. Again, this promotes a socialization process of learning and knowing.

Constructed Ways of Knowing

The focus on experience, authentic activity, and value of context is the premise of constructivist teaching. Constructed knowledge is a position in which the learner views all knowledge as contextual. The learner views themselves as creators of knowledge and values both subjective and objective strategies for knowing (Belenky, Clinchy, Goldberger & Tarule, 1986). The constructed way of knowing integrates knowledge the learner has felt intuitively was important to them, with knowledge they had learned from others. Belenky and colleagues (1986) speak to "weaving together the strands of rational and emotive thought and of integrating objective and subjective knowing" (p.134). "Constructivists move

beyond systems, putting systems to their own service and making connections that help tie together pockets of knowledge" (p.140). Are the opportunities for students to make these connections more available in the community setting? Is there a connection between these out-of-school and in-school experiences the respondents discussed? These critical questions serve to challenge nurse educators to think about the context for learning care in nursing education. This is further considered in the section that follows.

Context for Learning: In-School and Out-of-School Experience

Belenky et al. (1986) noted that in considering a design for education appropriate for women, one must begin with the question, "What does a woman know?" Although Belenky et al. (1986) concluded that academic coursework traditionally begins with the teacher's knowledge and not the student's, the women Belenky and her colleagues interviewed "nearly always named out-of-school experiences as their most powerful learning experiences" (p. 200).

These findings support the contextual circumstances of my respondents. Half of them reflected upon out-of-school experiences as powerful learning situations and / or situations they will never forget related to coming to know and understand care for older adults. In addition, the in-school experiences discussed were predominantly within the community setting rather than in an institutional setting such as a hospital or nursing home. Students connected the community setting with the opportunity to better come to know the older adult. Reflections regarding experiences associated with the hospital setting were seldom related to nursing school clinical practicum, and "lack of time" to get to know the patient and develop a relationship with them was a problem in the hospital context.

Kosowski (1995) studied how baccalaureate nursing students learn

professional nurse caring in the clinical context of nursing education. The author found that participants' interactions with patients was the context for the development of their understanding care. Participants narrated their stories about learning care by first describing their understanding of how they created caring with patients. "After uncovering the layers of their patient care interactions, they were able to answer the research question of how they learned caring in clinical" (Kosowski, 1995, p. 238). The need for these participants to describe interactions as they created caring has significance for the emergent themes in my study. Context is vitally connected to how students have come to know and understand care for older adults.

Discussing reform of nursing education for future practice, Oermann (1994) points out that, regardless of the setting for nursing practice, students need an understanding of the aging process and problems of the elderly if they are to be prepared for future practice. Citing work done with community college students, she advocates introducing students to the well elderly in the community before providing any experiences in hospitals or care facilities to sensitize the student to the aging process and to effects of aging on the individual and community.

Fox and Wold (1996) examined baccalaureate students' perceived learning and attitude changes as a result of a senior capstone course in gerontological nursing. Quantitative analysis of attitudinal scores indicated significant improvements in student attitude following completion of the course, and that community-based settings provided more positive experiences compared with institutional care settings. In addition, student responses to open ended questions indicated an increased awareness of issues specific to the older adult rather than knowledge of concrete facts about the aging process. "Students (in their

responses) shared shifts in their own attitudes or consciousness levels, based on their experiences" (p. 352). The authors noted that four students even indicated a reconsideration of career choice to a gerontological field. Two key themes were identified--an increased appreciation for the commonalities between the young and old of this society (labeled intergenerational commonalities), and the recognition of the ability of the elderly to actually contribute to society (labeled intergenerational sharing). The context of my respondents' reflections alludes to significant aspects of the knowledge construction process. This Contexts of Care theme is vitally linked to experience and as such will be the essence of the theme analyzed next.

Theme: Experience as a Growing Foundation

This theme depicts the significance of life experience as well as the types of experiences the students reflected upon as they discussed how they have come to know and understand care for older adults. The range of experiences discussed was broad and represented many aspects of the students' life. The commonalities in the responses were: (1) respondents were clear about the value of experience related to how they have come to know and understand care for older adults, and (2) these experiences represent many different aspects of the students' life as opposed to only experiences associated with the students' nursing education.

Value of Experience

Education literature is rich with thought about the value of experience in the learning process and the use of experience as a teaching method. The early works of John Dewey and the application of his theory in his Laboratory School evidence a unique use of experience to immerse the learner in a "web of opportunities" to play and work toward new understanding that was an ever broadening foundation on which to build subsequent experiences and discovery of knowledge (Mayhew &

Edwards, 1936). According to Dewey, all genuine education comes about through experience.

Building upon this thinking, Kolb (1984) proposed learning as the process whereby knowledge is created through the transformation of experiences. In his model, true learning is depicted as a four-part process. Learners have concrete experiences; they then reflect on the experiences from a variety of perspectives. From these reflective observations learners engage in abstract conceptualization, creating generalizations or principles that integrate their observations into theories. Kolb theorized that learning increased in complexity through this process likening the learning cycle to a transforming spiral of ever-increasing complexity. The respondents readily reflected upon their learning that had accompanied their various experiences. This transformation was an individualized process for each respondent.

Constructivist View

All respondents reflected upon experiences from childhood and / or within their family in response to many of the interview topics. These reflections conveyed a foundation for their attitude toward older adults as they described their experience or lack of experience with older adults as they were growing up. Those students who talked about their early and frequent exposure to grandparents or other older adults conveyed a comfort with them and used these experiences as foundation for constructing knowledge regarding care for older adults as they gained additional experience. This foundation was also retrievable for reflection upon in their transformational learning..."now I know why my grandparents do the things they do", or "I now have a new understanding of my grandmother's need to stay in her home." The students' reflections convey not only a comfort or lack of

comfort with older adults but also perhaps allude to the individual's sense of responsibility for other human beings. This reference to moral development will be further addressed in the analysis of the next theme.

In Kosowski's (1995) study of how professional nurse caring was learned, building on previous experiential knowledge was one of the care-learning modes identified in her study. Kosowski's participants recalled past experiences in their own or family members' lives that resembled the circumstances surrounding their present patient care situation. "Experiential knowledge from their former life histories was then 'built on' and blended with current 'nursing knowledge' to construct caring interactions with patients" (p. 240). The author described previous learning events that were "built on" by participants including kinship experiences as a parent, child, grandchild, aunt, or other family member. A few participants reported learning from personal experiences as hospitalized patients. Others reported building on knowledge gained from their previous employment. These findings are consistent with my respondents' reflections as they discussed patient care situations that reminded them of a frail aunt with failing health, a grandmother fighting to maintain her independence, or an uncle struggling with end of life decisions.

The value of individual life experiences in which the student personally encounters caring or non-caring has also been studied. Hughes (1993) examined peer group interactions and the student-perceived climate for caring. Her premise was that socialization of caring behaviors is bound to an environmental context that is shaped by the quality of the interactions that are experienced by the nursing student. She linked peer group interactions with the interpersonal socialization of students to a climate for caring. It was suggested that, to support caring as a

normative value for the practice of nursing, nurse educators must investigate means to nurture and sustain the ability of students to experience personally a climate for caring within the context of peer group interactions. In other words, attention must be given to supporting a caring environment in the classroom as well as other circumstances for peer group interactions such as student organization meetings and clinical practicum groups.

Another perspective, faculty-student interactions, has been studied as a foundation for learning care. Several studies have demonstrated the importance of role-modeling caring and matching teaching of caring with actions and curricula that enable the student to form meaningful connections (Nelms, Jones, & Gray, 1993; Grigsby & Megel, 1995; Dillon & Stines, 1996; Hanson & Smith, 1996; Simonson, 1996). These studies have shown the effectiveness and value placed on role modeling as a teaching-learning method by both nursing faculty and students. They have also addressed the power of caring and not-so-caring ways of being in teaching nursing students care as the essence of nursing. Thus, role modeling is not only a part of the formal curricula, but also part of the informal curricula--how faculty and administration interact with students as well as with each other. Noddings (1984) asserts that individuals cannot continue to care indefinitely without having caring returned. These nursing studies suggest that promotion of caring experiences among faculty and students may be a means of establishing communities of caring within colleges of nursing that facilitate connectedness and support. This appears to be a critical element of the socialization process involved in learning and constructed knowing.

My respondents' reflections did not convey caring role-modeled by nursing faculty or students overtly. Instead, Karen referred to "reciprocal" caring between

her patient and herself as she noted that she received as much from her patient as she gave to her. Margaret spoke of what she received from Sandy as she learned to care for this patient in a way that she had never experienced before. The caring that was returned to these students was from the patients. However, these clinical practicum opportunities for relationships with these patients over time were arranged and supported by the nursing faculty. These clinical practicum arrangements supported the evolution of the clinical experience as a medium for the learning and development of care. The climate for caring was arranged by the faculty to offer the student experiences that supported knowledge construction and created communities of caring within the clinical practicum. These were experiences students learned in as they engaged in what Wilson (1993) referred to as acting in the situation, and being acted upon by the situation.

Transformational Learning

The concept of transformational learning also emphasizes the impact of experience on adult education. This approach was alluded to earlier in the discussion regarding early childhood experience and stems from the idea that certain life experiences transform us. "Before the experience we were one sort of person, but after it we were another" (Clark, 1993, p. 48). This concept can be applied to aspects of the respondents' perceptions. The students were asked two questions that I believe solicited their perceptions regarding this transformational learning process. Students were questioned about a really powerful learning situation that they had related to care for older adults and to reflect upon the meaning that situation had for them. They were also asked to tell about a time when they came away from a care situation with an older adult thinking, "I'm never going to forget this situation because..." Although one student did draw on the

importance of a particular article to her, generally the respondents conveyed an active engagement in the experiences they reflected upon rather than being informed by reading articles, books, or being a detached observer. They discussed how subsequent reflection on these learning situations generated a new way of thinking about those circumstances that in turn had an influence on their approach to care for older adults.

These powerful learning situations ranged from early childhood experiences to recent patient care situations. Early childhood experiences included long term interaction with a caring nurse role model, or developing relationships with older adults and realizing that they had much to offer through their wisdom and stories. Recent patient care experiences associated with school and work included, discovering that an older adult's home could become their "prison" if they are unable to come and go as they once did, or a new understanding of loss, and a renewed commitment to dignity and respect. The commonality to these reflections was viewing the situation from a new and more abstract perspective; a vantage point from which subsequent similar experiences will have new meaning.

Challenges and Supports

Experiences that both challenge and support the students' growing foundation reflected transformational experiences encountered throughout the students' life span. This challenge / support process is recognized to be essential in student development (Sanford, 1962; Rogers, 1969; Thelen, 1972; Parker et. al., 1978; Perry, 1981; Kolb, 1984; Chickering & Reisser, 1993; Clark, 1993). Experiences such as comfortable childhood encounters with older adults, observation of ideal role modeling, experiences that foster self confidence, and being able to personally relate to situations provided the support that reinforced

these learners. Yet, experiences such as exposure to loss and loneliness, death and grief, and powerlessness and frustration, served to challenge the learner with additional realities and pose an opportunity for meaning-making from a different vantage point. Clark (1993) summarized that the focus on learning in terms of meaning formation for the learner is the reason the concept of transformational learning makes such a significant contribution to our understanding. This concept situates learning directly in the interpretation of the experience by the learner. The importance of reflection upon experiences and revisiting those experiences at different points in the student's development is the foundation of growth in meaning-making.

Feminist Pedagogy

Feminist theory has also addressed the role of experience in learning (Gilligan, 1982; Noddings, 1984; Belenky, Clinchy, Goldberger & Tarule, 1986). Application of feminist theory in education poses a different perspective with reference to students' life experiences within the context of a humanistic approach to education. Informed by feminist theory, educators are challenged to respect students' knowledge that emerges from first hand experience and support the student in building connections based on that experience.

Some would argue that these ideas are not new. Focusing on students' knowledge and building connections were the foundations of Dewey's Laboratory School. However, Collard and Stalker (1991) and Tisdell (1993) note that, although the idea of capitalizing on students' life experiences and relating theoretical concepts to those experiences is not new in adult education, focusing on a feminist pedagogy centering on the importance of women, in particular, reclaiming and validating the learning that comes from their life experience as

women, is new. They remind us that because women have a different relationship to institutional and public structures of power from that of men, there has been a tendency to dismiss or discount their learning that comes from experience in the private realm. Because the nursing profession continues to be dominated by women, I believe feminist pedagogy is an important element in this study. That respondents reflected upon many experiences outside their nursing education is significant. Valuing what the student brings to their education from the past and present, and how this is shared will be further analyzed as the second research question regarding teaching methods is addressed in a subsequent portion of this chapter.

Theme: Ways of Being

As the respondents reflected upon how they have come to know and understand care for older adults, a theme emerged that conveyed their common perceptions about "ways of being" with older adults. Respondents discussed an array of ways of being with older adults that depicted two patterns within this theme. One pattern connotes ways of being as a means of coming to know older adults. The students reflected on a range of ways of "coming to know" the older adult patient that they perceived permitted an individualization of care for that person. The essence of this pattern is the importance of sensitivity in the approach to nursing care for the older adult that is gained by means of coming to know them. The second pattern suggests ways of being with older adults that reflects the student's fundamental acknowledgement of the importance of treating older adults with respectful regard. The essence of this pattern is that authentic engagement in these ways of being was perceived to facilitate an openness to possibilities in interactions with older adults. This openness to possibilities also was seen as a

valued quality that would further permit one to come to know and understand care for older adults.

Ways of Knowing

That these students focused on the dynamics of ways of being as a means of knowing the older adult underscores Carper's (1978) theory of the Four Ways of Knowing. Carper identified four fundamental patterns of knowing from an analysis of the conceptual and syntactical structure of nursing knowledge. The four patterns are distinguished according to logical type of meaning and designated as (1) empirics, the science of nursing, (2) esthetics, the art of nursing, (3) ethics, the component of moral knowledge in nursing, and (4) the component of a personal knowledge in nursing.

Carper identified empirical knowledge as the factual, descriptive knowing that is generally ascertainable by direct observation and inspection. In contrast to this "science of nursing", Carper identified esthetic knowing as the "art of nursing," which involves "the active transformation of the patient's behavior into a perception of what is significant in it--that is, what need is being expressed by the behavior" (1978, p. 17). Carper places empathy as central to the esthetic pattern of knowing. Carper's pattern of personal knowledge is concerned with the knowing, encountering, and actualizing of what she identified as the concrete individual self. "One does not know about the self; one strives simply to know the self. This knowing is a standing in relation to another human being and confronting that human being as a person" (p. 18). Finally, Carper's ethical knowing is the ethical component of nursing focused on matters of obligation or what ought to be done. Carper's four patterns are not considered mutually exclusive but are interrelated and interdependent ways of knowing. As such, nursing, considered to be an

interpersonal process, involves interactions, relationships, and transactions between the nurse and the patient striving for an appreciation of the integrated whole of the individual.

Nursing intervention, based on a therapeutic relationship or interaction, is often referred to as a therapeutic use of self. Carper referred to this nursing role in discussing self. She believes the phrase therapeutic use of self implies that the way in which nurses view their own selves and the client is of primary concern in any therapeutic relationship.

> The nurse, in the therapeutic use of self, rejects approaching the patient as an object and strives instead to actualize an authentic personal relationship between two persons. The individual is considered as an integrated, open system incorporating movement toward growth and fulfillment of human potential. An authentic personal relationship requires the acceptance of others in their freedom to create themselves and the recognition that each person is not a fixed entity, but constantly engaged in the process of becoming. (Carper, 1978, p. 19)

Striving for this authentic personal relationship was evident as Jody spoke about getting the older adult patients' perspectives on their health and what they think they need, "...what they are scared of , what they enjoy, what they like, and what makes them happy." Kim talked about "reaching" her patients by finding out about the things that they want to do and over time knowing "more deeply about those people." Karen came to recognize her patient's fierce desire to remain in her home at all cost, the implications this had for this woman's fulfillment and Karen's nursing role as advocate for this woman in her process of becoming.

Personal and Esthetic Knowing

The pattern I have identified as Ways of Being as a Means of Knowing Older Adults depicts Carper's concepts of personal and esthetic knowing as way of developing a therapeutic relationship. Personal knowing was reflected in students'

perception of the need to develop a relationship, make connections, and get to know older adults. Esthetic knowing was reflected in the students' perception of the need to listen, understand, and empathize with the older adults. This pattern conveys student perceptions of how they have come to know and understand care for older adults by appreciating the integrated whole of the person. This was viewed as a means to facilitate sensitivity in their individualization of nursing care.

Research has been conducted to describe how nurses come to know patients and the importance of that knowledge in clinical judgments and decision-making in patient care situations. Benner (1991), Jenny and Logan (1992), and Jenks (1993) studied the concept of knowing the patient with nurses in practice.

Benner (1991) examined nurses' narratives for themes regarding decision-making in their nursing practice. Two major types of narrative were identified: constitutive or sustaining narratives, and narratives of learning. Each major type included several themes but in general were presented to illustrate the functions of narrative in everyday ethical expertise and socially embedded caring practices. Benner concluded that nursing must not rely on theories to distance it from skillful moral comportment in concrete, specific, local situations; but rather be tempered and taught by experience. "The relationship between ethical theory and skillful moral comportment must then be a dialogue between partners, each shaping and informing the other. Disengaged reason and rational calculation cannot replace engaged care as a moral source of wisdom" (Benner, 1991, p. 19). The students alluded to this engaged care as they reflected upon ways to be with older adults including: their need to develop relationships, understand / empathize, listen, make connections, and get to know older adults. The student reflections echo Benner's call for socially embedded caring practice.

Relationship of Knowing and Decision-Making / Clinical Judgment

That this practice of care is more than just a gracious way of conduct is substantiated by research on nursing practice in clinical judgment and decision-making. Jenny and Logan (1992) studied expert nursing practice in acute care conditions. The concept of "knowing the patient" was identified and determined to signify a cognitive and relational process. This process resulted in clinical judgments and decision-making relative to patient care outcomes. The authors concluded that the process of knowing the patient is an intrinsic dimension of nursing practice that permitted the individualization of care and as such constituted a unique contribution of nursing to quality patient care. "Failure to employ particularistic knowledge can result in standardized care approaches which [sic] may or may not be effective. Failure to utilize the knowing process can result in a lack of patient trust which [sic] can affect therapeutic outcomes" (Jenny & Logan, 1992, p. 258).

In a related study, Jenks (1993) examined the pattern of personal knowing in nurse clinical decision-making. She found that her participants described their success in making clinical decisions as highly dependent upon the quality of interpersonal relationships with patients, peer nursing staff, and physicians. The dynamic of interpersonal relationships and the difficulties in establishing them were identified as important influencing factors in nurses' clinical decision-making. Participants expressed a strong need to establish personal relationships with patients to facilitate clinical decision-making regarding their care. The nurses described that they needed to "know" their patients and this happened by "being with them." The author quoted one nurse describing knowing as more than knowing about patients... "Knowing about patients is important, but additionally,

nurses rely on having personal relationships with their patients... Getting to know my patients is the biggest help I have in deciding what my patients' needs are" (p. 401). Jenks noted that throughout the study nurses described many personal experiences where a decision was easier if they "knew" the patient. Many decisions that respondents perceived as difficult or in error were the result of not knowing the patient. Jenks believed that knowing, as described by her study participants, was a form of personal knowledge as conceptualized by Carper (1978). "Knowing is a unique form of knowledge that nurses gain only through interpersonal relationships. Knowledge gained from knowing is used by nurses in combination with cognitive knowledge, intuitive knowledge and experiential knowledge in making clinical decisions" (p. 403).

Knowing and the Nurse-Person Relationship

Additional related nursing research regarding personal knowing includes a study conducted by Mitchell and Heidt (1994). These authors explored the phenomenon of wanting to help another to uncover the structure of this lived experience. Participants in this study included eight nurses from a variety of practice areas including hospital-based nursing, public health nursing, private practice, education, and research. Through a phenomenological process, the lived experience of wanting to help another was explored as well as the dynamic of the nurse-person relationship. These authors identified three major concepts: directing intentions to nurture (participants choosing ways of being in the helping process), uplifting affirmations with others (a cherishing of relatedness, a valuing of the helping relationship and the persons encountered in these relationships), and dissonant constraints unfold new possibilities (awareness of limitations amidst opportunities). Although this research was based on the perspective of Parse's

theory of human becoming, lived experience and the value of relationships were again common themes.

Evans' (1996) observational study visit of several nursing care facilities and nursing schools in Scotland, Sweden, Norway, and Denmark focused on the process of individualizing nursing care. The participants placed high value on individualizing care, once again, through knowing the patient. In every setting, formalized, explicit nursing knowledge was less apparent than was tacit clinical know-how and intuitive responses. Specifically regarding care for older adults, "An underlying theme was respect for the inherent dignity of older patients as persons whose mostly lived lives, when understood, gave meaning to current behavior" (p. 17). These observations reaffirmed that knowing the patient is central to skilled clinical judgment and sensitive care for the older adult.

Knowing and Positive Relationship Focused Coping

Life span research regarding caregiver stress provides a different yet related perspective regarding personal knowing. Kramer (1993) studied caregiver depression and satisfaction among wife caregivers of husbands with Alzheimer's Disease. Kramer was interested in examining how caregiver coping might be different due to the interpersonal nature of its tasks by expanding on the Lazarus and Folkman (1984) conceptualization of caregiver coping from problem-focused coping strategies (managing or altering the problem causing the distress) and emotion-focused coping strategies (thoughts or behaviors aimed at regulating emotions and lessening emotional distress generated by the stressful situation). Kramer included in this conceptualization coping strategies proposed by DeLongis and O'Brien (1990) that focused on maintaining or disrupting social relationships. These strategies were identified respectively as positive and negative relationship-

focused coping.

Relationship-focused coping involved interpersonal regulation processes aimed at establishing, maintaining, or disrupting social relationships. The model proposed that modes of relationship-focused coping that may enhance or preserve relationships (positive relationship-focused coping) include negotiating or compromising with involved others, giving consideration to the person's limitations, and trying to understand / being empathetic. Modes of relationship-focused coping that may disrupt or damage social relationships (negative relationship-focused coping) included criticizing, ignoring, confronting, or minimizing contact with others.

Kramer found that the influence of relationship-focused coping was an important element in the caregiving outcome. Caregivers who were able to compromise, who considered their husband's limitations, and who were empathetic, experienced more satisfaction in the caregiver role than those who did not. These findings again underscore the significance of ways of being as a means of truly coming to know the individual on the receiving end of care by virtue of positive relationship building.

The Relationship of Knowing and Learning Care for Patients

Because very little qualitative research has been done with students regarding how they come to know and understand care for patients, Kosowski's (1995) study is again particularly instructive. In this study baccalaureate nursing students narrated their stories about learning caring by first describing their understanding of how they created care with patients. Participants' interactions with patients was the context for the development of their understanding of care. The author identified the relational themes of caring and interacting with patients. The similarities in the patterns in Kosowski's study are consistent with the outcome

of my study specifically related to the theme I have labeled Ways of Being. Due to these similarities Kosowski's patterns seem worthy of further discussion here.

In reference to learning care, Kosowski's participants identified the learning modes of what the author identified as the following patterns: role modeling, reversing, imagining, sensing, and constructing. Role modeling and reversing were identified as a paradox in that the caring behaviors role modeled were identified as significant learning tools as were those opportunities to see poor examples (reversing) and reflect upon the meaning this had for them as students in nursing. Imagining referred to the students' summoning their imagination to envision themselves or certain family members in a patient's circumstances. The author noted that successful use of creative imagination by participants in this study facilitated an intuitive knowing of patients' feelings and needs. "Through this creative process, participants gained insight into the patient's circumstances, needs, and desires....They remembered consciously reflecting on this intuited information, and ultimately gaining a confident awareness and understanding of the patients' circumstances" (Kosowski, 1995, p. 239). The author noted that following this process, participants felt they were able to respond with effective caring interventions.

Sensing was discussed by Kosowski's participants as a highly personal and intimate process of responding to a rising awareness of subjective feelings, emotions, and sentiment that occurred during interactions with patients. While in this learning mode, participants remembered perceiving and attending to bodily perceptions and memories.

> These bodily sensations were reported as the following: a "heightened awareness" of one's own feelings; an "openness to" "keying in to" and "interpreting" the patient's verbal and non-verbal clues; an appreciation of

> each patient's individuality" and the uniqueness of their situations; a "sensitivity" to personal reactions to patient situation; and , a "recognition" of the interface of past interpersonal experiences with the present patient encounter...Being "totally focused," "sensitive to," and "conscious of" perceptual information was a fundamental way of being while in this learning mode. (p. 239)

Constructing on previous experiential knowledge was the last caring learning mode identified in Kosowski's study. Participants recalled past experiences in their own or family members' lives that resembled the circumstances surrounding the present patient care situation. "Experiential knowledge from their former life histories was then 'built on' and blended with current 'nursing knowledge' to construct caring interactions with patients" (p. 240). The author described previous learning events that were "built on" by participants including kinship experiences as a parent, child, grandchild, aunt, or other family member. A few participants reported learning from personal experiences as hospitalized patients. Others reported "building on" knowledge gained from their previous employment.

> Participants remembered constructing caring knowledge by comparing similarities and differences among past and present experiences. They also recalled analyzing previous actions with comparable experiences, and determining them as either "successful" or "ineffective." Participants analyzed, transferred, and "built upon" prior relevant learning in order to gain an understanding of how to care for patients in the present clinical situation. (p. 240)

The respondents in my study echo many of these earlier research outcomes. Although the focus of this study was on care for older adults, the essence of the respondents' reflections are consistent with the personal knowing concepts of these reviewed studies. Kosowski's patterns reiterate the categories I have created in the pattern of Ways of Being as a Means of Knowing Older Adults. My

respondents clearly were concerned with the dynamics of personal knowing in individualizing nursing care, as the following passages illustrate:

> Anne: "You can't care for them if you don't know who they are."
>
> Jody: "You have to get their perspective on how they are feeling and about their life...what they think they need, what they are scared of, what they enjoy, what they like, and what makes them happy. It's getting their perspective on their health and what they think they need."
>
> Kirsten: (I like) "finding out their background, who they are, what their needs are, and what they feel their needs are so we can get a general consensus of those needs."

As the students discussed the means of coming to know the older adult, they identified ways of being that seemed to support this essential process of personal knowing. Getting to know the older adult entailed gaining insight into the individual's circumstances, needs, and desires. Making the connections that these respondents referred to and being open to and understanding / empathizing with the older adult's experience suggests the value given to ways of being as a means of personal knowing regarding the older adult.

Ethical Knowing

Returning again to Carper's (1978) Ways of Knowing, the concept of ethical knowing, the component of moral knowledge in nursing, must be readdressed here. Ethical knowing is specifically reflected in the second pattern of respondent perceptions in the theme I have labeled Ways of Being. In this pattern, Ways of Being as a Reflection of Esteem, students discussed ways of being as an end in itself--that is, ways of being as a means of reflecting esteem or regard for the older adult, which was perceived to be fundamentally important in interactions with these individuals. Carper speaks of ethical knowing as the component of moral

knowledge in nursing. "The ethical pattern of knowing in nursing requires an understanding of different philosophical positions regarding what is good, what ought to be desired, what is right; of different ethical frameworks devised for dealing with the complexities of moral judgments; and of various orientations to the notion of obligation" (1978, p. 21).

Students conveyed not only a sense of obligation but a growing appreciation or regard for the older adult, which seemed to shape their thinking about ways of being with these individuals. The students' responses that allude to this "how to be" with older adults--ways of being that reflect regard or esteem-- may be viewed from the perspective of the students' cognitive moral development or the development of the students' thinking about the relationship between self and society. This process is highly individualized and, depending on the epistemological perspective one considers, may be based on the stage of reasoning one has achieved (Kohlberg, 1976), the voice of care or justice to which one responds (Gilligan, 1982), and if one is bound by a moral imperative to care (Noddings, 1984).

Kohlberg's (1976) stages reflect a developmental process in which ideally the individual moves toward principled reasoning with defining values based on self chosen doctrines of justice, fairness, and equality. Gilligan's (1982) feminist perspective gives consideration to the differences in gender related to cognitive moral development. She differentiated the predominantly male voice of justice from the female voice of care that emphasizes the web of connection and a relational perspective tied to caring, empathy, and choice. Noddings' (1984) theory on caring speaks to a fundamental relatedness between the "one-caring" and the "cared-for." Noddings explained the role of the one-caring as the displacement of

interest from one's own reality to the reality of the other or trying to apprehend the reality of the other; it is a stepping out of one's own personal frame of reference into the other's. Noddings noted this is characterized by a move away from self and an engrossment or "feeling with" that involves a reception of the other into one's self.

The nursing profession continues to be a female dominant field. In this study, although ethnicity and gender were not criteria for selection, all respondents were Caucasian women. This representation reflects the persistance of female gender dominance in nursing and, as such, contributed to the depth of this study's data. Though the respondents represented a range in ages from early 20s to early 40s, the voice of care was evident in all their reflections. These respondents alluded to an increasing understanding of the relationship between self and others. This was particularly evident as they related experiences in which they sought to know the older adult through attempts at understanding or empathy, personally identifying with the patient's circumstances, and questioning the meaning these circumstances had for their life. These respondents related the impact these patients had on them personally; how they changed their way of thinking about loss, dementia, AIDS, and loneliness. They talked about what they had "received" from these patients and the pleasure they derived from coming to know them. Noddings (1984) suggested that caring does not happen without gain for the one-caring. She noted that joy often accompanies a relatedness with the cared-for. "It is a special affect that arises out of receptivity of caring, and it represents a major reward for the one-caring" (p. 132).

Transpersonal Caring Relationship

Watson's (1988) Human Care theory of nursing speaks to this receptivity or relationship also in reference to the transpersonal caring relationship. According to

Watson, "A transpersonal caring relationship connotes a special kind of human care relationship--a union with another person--high regard for the whole person and their being-in-the-world. Caring, in this sense, is viewed as the moral ideal of nursing where there is the utmost concern for human dignity and preservation of humanity" (p. 63). Watson identified several elements a transpersonal caring relationship depends upon including:

> 1. A moral commitment to protect and enhance human dignity, wherein a person is allowed to determine his or her own meaning.
> 2. The nurse's ability to realize and accurately detect feelings and the inner condition of another. This can occur through actions, words, behaviors, cognition, body language, feelings, thought, senses, intuition, and so on.
> 3. The ability of the nurse to assess and realize another's condition of being-in-the-world and to feel a union with another. The subjectivity of the patient is assumed to be as whole and as valid as that of the nurse.
> 4. The nurse's own life history (casual past) and previous experiences and opportunities of having lived through or experienced one's own feelings and various human conditions, and of having imagined others' feelings in various conditions. (p. 64)

Watson's Human Care theory of nursing speaks to a receptivity or relationship in reference to the transpersonal relationship that echoes the reciprocal relationship some of the respondents in this study described.

> Human care can begin when the nurse enters into the life space or phenomenal field of another person, is able to detect the other person's condition of being (spirit, soul), feels this condition within him or herself, and responds to the condition in such a way that the recipient has a release of subjective feelings and thoughts he or she had been longing to release. As such, there is an intersubjective flow between the nurse and patient. (p. 63)

Watson's theory assumes a set of values associated with a deep respect for the wonders and mysteries of life, acknowledgement of a spiritual dimension to life, and internal power of the human care process, growth, and change. Human care

requires high regard and reverence for a person and human life, nonpaternalistic values that are related to human autonomy, and freedom of choice. In this study, the pattern of Ways of Being as a Reflection of Esteem reflects these values. Respondents cited the values of: respect, patience, acceptance, advocacy, being open to learn from older adults, identifying their unique needs, promoting independence and autonomy, and seeing strength and potential in aging.

Watson believes the context for viewing the person (patient) and the nurse in transpersonal caring is in the moment-to-moment human encounters between the two people. "It is not so much the 'what' of the nursing acts, or even the caring transaction per se, it is the 'how' (the relation between the what and the how), the transpersonal nature and presence of the union of two persons' souls, that allow for some unknowns to emerge from the caring itself" (1988, p. 71). I believe this differentiation of the "what" of the nursing acts and the "how" mirrors this study's respondent reflections. These students were talking about "how" to be with older adults, "how to be" as a human care response, conveying the high regard and reverence for a person that is referred to by Watson.

Opinions: What is Authentic Care?

That caring can be perceived differently by different people must also be considered. Komorita, Doehring, and Hirchert (1991) examined perceptions of caring by nurse educators, managers, and advanced practitioners. These were compared to patient perceptions of caring. These authors found that with the exception of the behaviors of listening and talking, there was disagreement about what constitutes the most important and least important caring behaviors. They found that patients valued activities that represented "being cared for" while nurses placed importance on behaviors that indicated "caring about" the patient.

This overt difference may be similar to what Bishop (1990) referred to when she described authentic caring. She believed that nursing education prepares students for both taking care of patients and fostering their self-care. Bishop believed that taking care of patients, to be justified, must occur only when the patient is unable to care for him or herself. "When patients are able to care for themselves and yet dependent care is given, care is taken from the patient. When nurses help patients learn self-care, they are practicing authentic care" (p. 74). The respondents in my study alluded to authentic care as they discussed the need to maintain the patient's autonomy and independence. The need to know the patient, to determine how best to practice authentic care, was the issue.

And what are older adults' perspectives on caring? Nordgren and Johnson (1995) interviewed older adults to understand their impression of caring and non-caring nurses' behavior. Related to caring, older adults identified themes of the care giver's giving of self, consideration of the older adult's individuality, and caring interactions which included behaviors and attitudes of compassion that made the older adults feel like their needs were being met. Noncaring themes identified were: lack of "presence" by the nurse as evidenced by their expressions; the nurse's expressing personal and private concerns; client individuality not being met; and nurse's lack of concern through noncaring behaviors that made the older adult feel that their needs were not being met.

The older adults interviewed also identified themes related to teaching nursing students that included: showing respect through voice tone and affect; consider the client's perception of physical needs; meet spiritual needs; use the wisdom of the older adult and educators to foster confident nursing care; nurses should take care of themselves; and the need to advocate for the older adult.

The authors concluded that "the best source of information about the older adult is the older adult" (p.38). They encourage nurse educators to support the interactive role of nursing with the older adult; to convey the value of obtaining the older adults' perceptions and allow opportunity for students to be with older adults and reflect on their life experiences. Enriching the student's life experience with opportunities to develop relationships with older adults and "learn" from them would seem a crucial element in the student's foundation for authentic human care.

My respondents spoke of their older adult patients "teaching" them what it is like (and not like) to grow older. Karen spoke of her patients having so much knowledge and life experience to share and how meaningful this was to her. Kirsten also spoke of listening and learning from her older adult patients. Margaret reflected on the older adults' wisdom as a result of having "been through life" and that this wisdom could teach her much. Similarly, Kim reflected on learning about how the older adults' life events changed them and how this could help with ones own personal decision making. And Anne, reflecting on the strength and potential of older adult women facing multiple losses, acknowledged enlightened thinking and a change in attitude. Clearly these respondents acknowledged their older adult patients as teachers with much wisdom to be shared.

Theme: Teaching and Learning Care for Older Adults

The thematic analysis leads to the second major research question, which is as follows: Based on the nature of perceptions and existent literature, what teaching methods / tools might best nurture baccalaureate nursing students coming to know and understand care for older adults? How can nursing curricula be better shaped to allow students to come to know and understand care for older adults--a population whose complex and profound needs will continue to

challenge health care providers far into the future?

To address this research question I revisited the respondents' reflections in the emergent themes to draw out possibilities related to curriculum design. In addition, specific respondent reflections that offered thoughts and suggestions regarding teaching and learning were unitized. Student recommendations were consistent with fundamental concepts within the emergent themes. The themes: Contexts of Care, Experience as a Growing Foundation, and Ways of Being were addressed as the students suggested creating opportunity to develop relationships with older adults that would challenge and support coming to know and understand their care needs. These opportunities went beyond nursing education as the respondents alluded to a wide range of early and continuing connections that ultimately center on social responsibility. The use of journal entries for document review in this study and reference to a need for reflection and assimilation conveyed a more specific curriculum direction and is supported by the literature. The following discussion will merge these thematic curriculum implications with, and draw support from, the literature / theory in related fields.

Feminist Pedagogy in Curriculum Design

Feminist theory addresses the role of experience in learning. Application of feminist theory in education has gained increasing attention and perhaps a slightly different perspective with reference to students' life experiences within the context of a humanistic approach to education. Belenky, Clinchy, Goldberger and Tarule (1986) refer to connected teaching as focusing on the individual's life experiences and appreciating women's different "ways of knowing." According to Belenky et al., in connected teaching, the teacher examines the needs and capacities of the learner and composes a message that is, as the authors quote psychologist

Jerome Bruner's term, "courteous" to the learner.

Belenky et al. (1986) allude to constructivist teaching when they speak of the "connected teacher." "Connected teachers focus on the student's knowledge and engage the student in the process of thinking in an open dialogue that becomes a cycle of confirmation-evocation-confirmation between the student and the teacher" (p.219). The teacher's primary concerns are for the preservation of the learner's "fragile thoughts" and to foster and support the evolution of the student's thinking, to nurture the thought, and to allow it to grow. These authors were referred to earlier in reference to the value they placed on the learners' life experiences. Here, this value is aligned with the connected teacher's focus on the student's knowledge rather than their own. The authors believe this fosters a cyclical open dialogue between the student and the teacher of problem-posing to engage the student, and that through this cyclical dialogue, the roles of the student and the connected teacher merge.

Candy (1991) noted this type of teaching assumes that learners are active knowers who participate in their construction of knowledge, and that novelty and change are part of most learning situations. The aim of teaching from this framework is not just transmitting knowledge, but negotiating meaning embedded in the multifaceted realities that students bring with them to learning experiences.

The role of experience and prior knowledge takes on particular significance in differentiating adult learning from learning during childhood. Caffarella and Barnett (1994) discussed the complimentary nature of the knowledge bases of adult learning and experiential learning. A common theme noted from the literature seemed to be the comparatively richer life experiences and background of the "adult." With increasing age comes more life experiences to draw upon both in

numbers and in context. This proved to be true for one respondent, Anne, who was in her forties. Anne frequently reflected on the experiences she had related to the deaths of her uncle, father, and mother-in-law. The other respondents, who were younger, had not encountered as many family losses or challenges related to issues of aging.

The uniqueness of each individual's life experiences and background not only differentiate children from adults, but also one adult from another. Adults can not only call upon their past experiences and prior knowledge, they can serve as resources for each other during learning events as well (Caffarella & Barnett, 1994). Eyres, Loustau, and Ersek's (1992) findings support this perspective. They studied knowing among beginning nursing students based on the Belenky et al. (1986) typology. They found that the invaluable practical knowledge gained through experiences in family life, partner relationships, and childrearing made the older students "treasures in the recruitment efforts" (p.180). The authors believed these students' experiences provided a strong foundation for the personal commitment and transitions necessary in professional nursing.

In my study, the respondents' wide range of experience, and their conviction about the value of experience in coming to know and understand care for older adults, underscores the need to facilitate knowledge sharing among students. Opportunity to grow from each others' vast array of experience would offer rich opportunity for meaning-making.

Noddings (1984) discussed teaching as caring and how caring functions in an educational context. Her approach also emphasized the receptivity and responsiveness of feminist pedagogy. According to Noddings, the teacher, as one-caring, receives and accepts the student's feeling toward the subject matter, as the

one-cared-for. The teacher, as the one-caring, looks at the subject matter and listens to it through the learners's eyes and ears. Noddings believes that as this "inclusion" is practiced, the teacher accepts the learners' motives and reaches toward what the learner intends (so long as these motives and intentions do not force abandonment of the teacher's own ethic). This inclusion is seen as a vital gift of the teacher to the learner. Within this caring relationship, the teacher attempts to understand from the student's perspective and is totally and non-selectively present to each student.

Noddings (1984) sees this view as not romantic but practical. The teacher works with the student. The student becomes an apprentice of sort and gradually assumes greater responsibility in the tasks the teacher and learner are undertaking.

> The one-caring as teacher, then, has two major tasks: to stretch the student's world by presenting an effective selection of that world with which she (the teacher) is in contact, and to work cooperatively with the student in his struggle toward competence in that world. But her task as one-caring has higher priority than either of these. First and foremost, she must nurture the student's ethical ideal. (p. 178)

The inclusion that Noddings refers to is gaining recent attention in multicultural education literature (Gollnick & Chinn, 1990; Anderson, 1990; McCormick, 1994). Educators are challenging us to strive for curricular inclusivity by valuing diversity, promoting social justice, and acknowledging multicultural and gender issues. We are reminded that old age is considered an unrecognized minority culture that, like other minority groups, has been victimized, exploited, and oppressed (Markides & Mindel, 1987; Margolis, 1990; Butler, 1993). There are a number of methods to operationalize inclusive, connected, contructivist teaching, such as discovery, exploration, modeling, case study analysis, critical incident

techniques, simulation and role play, reflection activity and reflective writing (Bevis & Watson, 1989; Diekelmann, 1990; Atkins & Murphy, 1993; Gioiella, 1993; Brody & Witherell, 1994; Halloran & Dean, 1994; Sorrell, 1994; Beck, 1995; Darbyshire, 1995; Nehls, 1995; Fox & Wold, 1996). These methods create a foundation for valuing experience and the transformational learning processes that have been referred to earlier. The reflection that was evident in these students' responses directed subsequent analysis and literature review.

Reflection in Education

The concept of reflection has been alluded to in reference to finding meaning in life experiences and the transformational learning process for the adult learner. The value of reflection activity has regained attention in the last twenty years as a method to support knowledge construction (Mezirow, 1981; Kolb, 1984; Schon, 1987; Barnett, 1989; Tremmel, 1993; Jackson & MacIsaac, 1994; Caffarella & Barnett, 1994) . Reflection is the opportunity for the learner to make meaning of their own experiences by formally reviewing prior experiences and viewing them through a new lens. Schon (1987) referred to reflective practice as the process of bringing past events to a conscious level and determining appropriate ways to think, feel, and behave in the future based on the reflective activity. According to Schon, through reflection, the learner has an internal dialogue with oneself. The learner uses experience, intuition, and trial-and-error thinking to define, solve, or rethink a particular problem or dilemma they may be facing or have faced. "Reflection may focus on a variety of issues, including the tacit norms underlying a judgment, the strategies behind an action, the feelings associated with an event, or the specific role a person is trying to fulfill" (Caffarella & Barnett, 1994, p.38).

Schon (1987) described the way in which educators can facilitate reflection

in practice by centering around the concepts of reflection-in-action and reflection-on-action. Reflection-in-action is a process used by learners to challenge assumptions about their work or activity while they are doing it, critically examining their present time actions, and testing alternatives that reshape what they are doing while they are doing it. In contrast, reflection-on-action is a process used by learners to look back on action already taken, critically analyze reasoning and data, and evaluate by testing that action. This results in forming a new perspective for future action. While looking back on experiences and analyzing behavior and thoughts, the student begins to explore the assumptions and understandings brought to her / him through the experience.

Schon's (1987) reflection activity would support the constructivist model. He believes that it brings learning and doing to the forefront of the education experience.

> Students do not so much attend these events as live in them (p.311). .... A reflective practitioner must be attentive to patterns of phenomena, skilled at describing what he observes, inclined to put forward bold and sometimes radically simplified models of experience, and ingenious in devising tests of them compatible with the constraints of an action setting. (p.322)

There have been numerous education models for reflective thought and action. Kolb's (1984) model, discussed earlier, is a four-part reflective cycle that is a process of transformation of experiences to create new knowledge. Caffarella and Barnett (1994) have extended this model to include planning for implementation or an action plan for the future. It is believed that adding this step to the model would encourage the learner to take action based on the insights gained from the abstract conceptualization phase of Kolb's fourth step.

Mezirow (1981) viewed reflection as a "process of critically assessing the

content, process, or premise(s) of our efforts to interpret and give meaning to an experience" (p.14). Through this process learners looks at their own actions and thoughts as a process of reflective action that begins with posing a problem and ends with not only problem solving but again, more importantly, taking action. As with Barnett's model, the emphasis is on action as the end product of the reflective process.

Tremmel (1993) has asked us to rethink how we operationalize the reflective process, from a linear model that is set in motion by a problem or a dilemma, to one of being "mindful" of what is going on around us at all times... "When one is mindful, one lives in the present and pays attention to that present" (p.444). He viewed paying attention to the present as both "paying attention not only to what is going on around us, but also within us" (p.447). Tremmel's premise was that as educators we need to assist learners to be mindful of what they are thinking and feeling during the reflective process and to use those free-flowing thoughts and feelings as the point of departure for reflection within self versus reflection on a specific event or problem.

Jackson and MacIsaac (1994) discussed what they called "features of successful learning" and related the conceptual foundations of experiential learning with authentic learning experiences and constructivism. "This perspective on learning stresses that active participation in and active reflection on the learning process are essential features of successful learning" (p. 22). Reflective practice was discussed as a foundational concept of experiential learning. The authors concurred with Schon that the reflective practice of recapturing an experience, thinking about it, mulling it over, and evaluating it, is an essential ingredient in the experiential learning process.

And yet this essential ingredient is not without some risk. Caffarella and Barnett (1994) cautioned educators that care must be taken to give learners the time and support they need to work through what this new learning perspective may mean for them. They noted that often the new perspective may bring forth feelings that are not easy for the learner to process; generating feelings that must be acknowledged, and allowing time for this process to evolve.

My respondents conveyed the need to have the opportunity to come to know older adults. Often the examples given were depictions of meaning-making that occurred over time and was a result of reflection-on-action that took place formally or informally. "I'll never forget this situation because..." and discussion about "a powerful learning situation" evoked thoughts that reflected meaning-making based on assimilation and review of the situation within the whole of this students' life experience to date. Anne summarized with: "If I just had time to reflect on that article...I would have learned so much more..." In this study, the spoken and unspoken reference to reflection and the need to "have time" for this activity seems to be significant and consistent with a feminist pedagogy in education.

Journaling, Narrative, and Storytelling in Education

A method that has gained relatively new attention with reference to higher education is that of the use of journaling, narrative, and storytelling. The power of lived experiences and the value of opportunity to reflect upon these experiences for meaning in context is realized through written dialogue and storytelling within a journal format. This method does indeed allow for the reflection-on-action of experiences that Schon (1987) and others suggest. In addition, it offers practice at the skill of describing observations and patterning of phenomena.

Much can be found in recent literature on the use of these strategies in a

variety of educational settings. In Toby Fulwiler's The Journal Book (1987), chapter authors give support to the purpose and value of the use of journals to help students "seek, discover, speculate, and figure things out" (p.9).

One contributing author, Berthoff (1987), argues that the fundamental use of language is to make meaning and that double-entry journals are one of the best places for this to happen. She described use of a dialectical notebook as such: "...dialectic and dialogue are closely related; that thinking is a dialogue we have with ourselves; that dialectic is an audit of meaning--a continuing effort to review the meanings we are making in order to see further what they mean. The means we have of doing that are--meanings" (p.12). She suggested an ongoing review of the journal entries "to look and look again", "to return to assumptions", and learn to question. Reminiscent of Dewey, she stated that engagement with their journaling supports the student's learning to question. "Questioning is problem-posing and it engages the mind more radically than problem-solving" (Berthoff, 1987, p. 16).

Brody and Witherell (1994), Klein (1994), and Cooper (1994) discussed the power of these methods in classes with professional students. Brody and Witherell (1994) described the use of story telling and journaling as a strategy in a graduate core curriculum with students from five different professional programs. In developing this class the authors "assumed that adults, as well as children, are natural storytellers, though they have often learned to suppress their urge to tell stories as evidence of knowing (or even experiencing) because of the dominant theory of knowledge as 'objectivity and generalizability' within the academic world" (p. 71). They noted that experiential learning coupled with an emphasis upon narrative and the personal story as the thread of the life course, proved to be an exhilarating combination.

Brody and Witherell (1994) believed that narrative ways of knowing have been devalued in western science because of their "serendipitous ability to integrate the seemingly paradoxical" (p. 74). The power of narrative allows the individual to continually locate and relocate his or her own voice within a social and cultural context. Narrative and dialogue give each person what feminists call "voice." Regarding creative synthesis stories, the authors proposed that these stories join the worlds of thought and feeling. They noted that stories connect the author's analysis of self, gender, and culture with their feelings--feelings of joy, sadness, aloneness, anger, and fullness of relation. In their discussion of use of stories the authors acknowledged the centrality of affect and subjectivity in human ways of knowing.

Klein (1994) also described a course with professional students in which critical reflection was fostered through small and large group dialogue as well as journal writing. Klein noted that ..."it is in the journals that ideas really blossom, as many students speak about troubling experiences they have been contending with for some time" (p.100).

Cooper (1994) discussed the importance of dialogue and journal writing as a powerful, reflective practice that promotes adult learning and context-embedded critical thinking. He described adult learners' use of classroom journals as a way of examining organizational and professional life and talked about the use of the journal in reaching "some integration of personal and professional identity" (p.103). Cooper acknowledged some students' fear of writing and resistance in dealing with past experiences, and noted the importance of support and provision of a safe atmosphere for exploring these experiences and responding only to the content.

Much of the narrative provided for document review in this study was

journaling and written reflection on projects that were used as class assignments. The journaling conveyed indepth what the students spent much time discussing during our interviews. The richness of detail in these written reflections was profound. In reviewing these documents, I noted the consistency of what they conveyed with what the respondents reflected in our discussions. During second round interviews, clarification of the significance of the documents to the respondents consistently brought us back to discussions that were a reinforcement of their earlier thoughts. In reviewing the main issues of each of the documents, I found them all to depict the student making meaning of a particular experience the document was chronicling in some way. This meaning-making connoted a transformational learning experience in all cases. Students were seeing something in a new way or revisiting previous ways of thinking about something and expanding their thinking to include an additional vantage point. All of the documents represented the students' reflection and a knowledge building process that seemed to provide them with enhancement of their ways of knowing. I also noted that many more of the documents the students chose to share with me represented community-based experiences rather than institutional-based experiences.

During our interview, Anne discussed the need to have the opportunity for reflection. (She was not in a class that required much journaling or written reflection.)

> Anne: I often would think, give me time to read this...to understand what it's saying, but I didn't have time. (There needs to be time) to assimilate what you've learned. If I just had time to reflect on that article...I would have learned so much more.
>
> In school I was so stressed and the people that I worked with were so stressed in getting done what we had to get done, that we never really could reflect on what we were learning. Now, just being out of school three

months, I have started to kind of assimilate things...

How can nursing curriculum be designed to challenge students with techniques of meaning-making to nurture the mindful, reflective practitioner? This invitation to consider curriculum possibilities in nursing education will be further examined next.

Feminist Pedagogy in Nursing Education

Nurse educators have become increasingly aware of the need for transformation of nursing education from a behaviorist model to an emancipatory-educative-caring model (Bevis & Watson, 1989; Boykin, 1994). Since the mid-80s, formalization of these concerns resulted in the development of a contemporary movement identified in nursing education literature as the "curriculum revolution" (Bevis & Murray, 1990).

This curriculum revolution has as its foundation many of the experiential, constructivist, transformational learning concepts found in contemporary education literature (Rogers, 1969; Thelen, 1972; Kolb, 1984; Clark, 1993). The redirection from the traditional behaviorist approach to a feminist, connected teaching approach is reflected in the consideration given to ways of knowing including Belenky, Clinchy, Goldberger, & Tarule's (1986) work as well as Carper's (1978) patterns of knowing. Contemporary nursing research has attempted to explain knowledge construction in nursing care. Phenomenological approaches to inquiry have explored clinical nursing experiences and professional nurse caring (Benner, 1991; Benner, Tanner, & Chesla, 1992; Jenny & Logan, 1992; Diekelmann, 1993; Mitchell & Heidt, 1994; Kosowski, 1995). This work has influenced trends in nursing education, which include a renewed interest in the role of experience / practice in learning human care, knowledge construction and ways of knowing in professional nursing practice, and methods to support critical thinking, inquiry, and

synthesis including reflective practices (Boykin, 1994).

Jenks (1993) studied Carper's (1978) pattern of personal knowing in nurse clinical decision making. She found that her participants described their success in making clinical decisions as highly dependent upon the quality of interpersonal relationships with patients, peer nursing staff, and physicians. The dynamic of interpersonal relationships and the difficulties in establishing them were identified as important influencing factors in nurses' clinical decision making. Jenks concluded that "nurse educators have known for a long time that students need to improve their interpersonal relationship skills with patients. We have not, however, appreciated that these relationships provide the student with a special kind of knowledge that is essential for effective clinical decision-making" (p. 404). Jenks believed that viewing decision making as a purely cognitive activity is short-sighted. Teaching practices for nurse clinical decision making should reflect the multiple patterns of knowing required for this complex activity. Educational efforts focused on effective clinical decision-making should include skill building in cognitive, intuitive, and interpersonal skills.

Relationship Building

How then does nursing education support students in learning these cognitive, intuitive, and interpersonal skills grounded in multiple ways of knowing? Beck's (1995) study of a cooperative learning teaching model in nursing education included a sample of 27 registered nurses who were continuing their education to pursue a baccalaureate degree in nursing. Beck noted that although there was evidence in the literature of successful application of cooperative learning strategies in the college setting, there were no studies reflecting use in nursing education.

Beck incorporated principles of feminist pedagogy into the class she taught on professional nursing using cooperative learning strategies as the primary teaching modality. Applying cooperative learning principles, Beck's students worked together in teams or groups to learn through what Beck called transactions. With the predominantly female population of nursing students, application of feminist pedagogy complemented the cooperative learning model as consideration was given to the way women know and learn. Beck noted that feminist theory identified the need for relationships and connectedness for women in their learning experiences, decision making and coming to know, thus supporting multiple patterns of knowing.

Beck found that the cooperative methodology was effective in her nursing education experience. The feminist pedagogy in the classroom fostered cooperation, collaboration and a collective process. Beck noted the class was an attempt to create a place where students felt safe and could learn from each other, authority was negotiated, and disagreements were encouraged. It was felt that in particular, the use of both small group and large group discussion facilitated participation, as students took responsibility for their own learning and became active participants in the educational process.

In my study, respondents not only conveyed a value of experience, they underscored the range of in-school and out-of-school experiences that facilitated critical inquiry, synthesis, knowledge construction, and reflective practice. A cooperative methodology could assist students in valuing what they bring to their nursing education and support an openness to value others' lived experiences and therefore promote the advantage of shared practice.

Reflection and Narrative in Nursing Education

In reference to the use of reflection in nursing education, Atkins and Murphy (1993) completed a literature review to identify the skills required to be reflective and attempted to differentiate reflection from analysis. The skills they identified included self-awareness, description, critical analysis, synthesis and evaluation. They noted that the primary difference between analysis / synthesis, and reflection was that reflection involved self and "must lead to a changed perspective" (p.1191). The authors concluded that, since practice is central to nursing education, if learning is to occur from practice, then reflection is vital.

Nehls (1995) referred to self-reflection in her discussion of narrative pedagogy in nursing education. She emphasized the centrality of the lived experience as revealed in narratives developed by students. "Through description and hermeneutical analysis of experiences, students derive meaning from what's imminent in nursing" (p.206). Nehls noted that, through nursing situations, learning by self-reflection prepares students to think about the centrality of caring and dialogue in nursing practice. She believed narratives teach and evoke reflective thinking about aspects of nursing practice that are often absent in textbooks or difficult to grasp without practical experience.

Sorrell (1994) discussed writing as a valuable medium for informing esthetic knowing in nursing. With reference to Carper's Patterns of Knowing, she noted that exploration of the fundamental patterns of empirical, ethical, personal, and esthetic knowing has shaped today's conceptualization of nursing. However she noted that the esthetic pattern of knowing is only "dimly reflected" in nursing practice. "The literature acknowledges the importance of the 'art' of nursing, as well as the science, but much more is written about 'doing good science' than about seeking

new understandings through the esthetic ways of knowing" (p.61). Sorrell encouraged nursing to return to the concept of esthetic knowing to inform the art of nursing. She offered suggestions to be included in curriculum such as the use of composition, expressive and poetic writing, including written narratives, and journals as a mode of inquiry for reflection on past experiences. Sorrell noted that narratives will often reflect a "special knowing that is not from the intellect but from the senses" (p.67).

A grounded theory approach was used by Davies (1995) to study first-year, undergraduate nursing students and the use of reflective teaching methods. She found that the use of the reflective processes of clinical debriefing and journaling had an influence on the environment, the process, and the focus of learning for these students. She noted that students moved from a passive to a more active mode of learning and that over time, reflective processes resulted in a "shift of focus from self in the system to client in context"...."In journaling, the perception of the client was broader and more abstract issues were considered" (p.172).

Diekelmann's (1993) hermeneutical analysis of lived experiences of students and teachers in a baccalaureate nursing education program uncovered shared practices and common meanings of her respondents. Diekelmann's concern was the consistent focus on content in teaching practices which she believed could conceal what was being learned, or rather the meanings that the student was taking on. By focusing so much of the student's attention on content, Diekelmann believed that teachers have inadvertently encouraged students to practice memorization and decontextualized rote learning rather than the process of thinking skillfully. Diekelmann suggested alternatives to traditional teaching methods that encouraged learners to reflect upon possibilities and contingencies:

> It is not about teaching one kind of knowledge or another, but rather creating a place in the curriculum to have the ongoing dialogues among students and teachers to enable a balance that is meaningful. The issue for us to think about as we transform nursing education is the 'how' of preserving the integrity of courses and content and analytic thinking while attending to the evolution of practical knowledge and situated or reflexive thinking. (p.249)

Darbyshire (1995) described a teaching method that he believes promotes the study of human experience in a unique interpretive means. His nursing humanities course titled "Understanding Caring Through Arts and Humanities" focused study of the human experience through the esthetic dimension of the arts and literature. He believes that this approach challenges, stimulates, integrates, and develops students' thinking and understanding of the lived experience of patients in ways that more traditional scientific and behaviorist approaches to nursing education are unable to do. The opportunity to reflect upon lived experiences through stories, poems, and other art forms calls upon the esthetic way of knowing that Carper (1978) suggested is essential as a way of being in caring.

In my study, the respondents discussed making meaning and developing a practical knowledge that was indeed situated in reflective thinking--the very opportunity to engage in the dialogue with me, as a researcher, provided yet another opportunity for narrative, meaning-making, and shared practice. The value of the opportunity for reflection through dialogue and / or written narrative for meaning making and mindful practice was clear from these respondents' voices.

Curricular Application to Gerontology Nursing

There is very little literature regarding curricular application of the afore-mentioned concepts in relation to learning care for older adults. Actually, focusing only on the older adult as a specific population is not consistent with the holistic

approach to professional nursing practice espoused by the curriculum revolution. And yet, the statistics and other facts that were the trigger for this study continue to draw me to focus on care for older adults as a specific health care challenge for nursing education in the future.

Fullerton, Lantz and Quayhagen (1992) reviewed the didactic and clinical focus of geriatric curriculum content within both associate (ADN) and baccalaureate (BSN) schools of nursing in California. They found that the psychosocial, cultural, and environmental aspects of geriatric nursing care are deferred to advanced levels of nursing education (at least the BSN, and likely, to graduate programs). They also found that the focus of geriatric content at the ADN level was physiological only and lacking in context of geriatric health care. This finding has startling significance when consideration is given to current staffing circumstances in most extended care facilities. Those with responsibilities for direct patient care are those who are lacking in a foundation in the context of geriatric health care.

Regarding baccalaureate nursing education, there does seem to be a renewed interest in innovative approaches to incorporating gerontology curriculum into the nursing program of studies. Matzo and O'Reilly (1993) and Philipose (1993) proposed methods to increase gerontologic nursing knowledge and skills of both faculty and students. Matzo and O'Reilly (1993) reported on the development of a new faculty role in their institution titled a "gerontology integrator." This approach was an outcome of a decision to integrate gerontology into the entire nursing curriculum rather than having a separate gerontology course. The gerontology integrator functioned as a resource as well as clinical instructor to enhance competence in caring for older adults in the spectrum of clinical settings in

the baccalaureate program studied.

In contrast to this integration approach, Philipose (1993) reported on the development of an elective interdisciplinary course on aging that was developed for college students including nursing students. This course included many creative teaching approaches that helped students gain knowledge and sensitivity to the experience of aging. The author reported that, "Without exception, all of the students commented that the aging content was very useful...and that their perceptions of the elderly had been altered" (p. 97).

Oermann (1994) discussed reform of nursing education for future practice. She pointed out that regardless of the setting for nursing practice, students need an understanding of the aging process and problems of the elderly if they are to be prepared for future practice. Citing work done with community college students, she advocated introducing students to the well elderly in the community before providing any experiences in institutions to sensitize the student to the aging process and effects of aging on the individual and community. She believes that experiences with the aged provide an opportunity for students to examine the impact of aging on both women and men and the powerlessness that many feel as they age within our society.

Scheffler (1995), and Fox and Wold (1996) have studied change in nursing students' attitudes toward care of older adults as a result of gerontology curriculum. Scheffler's (1995) descriptive study examined associate degree students' attitudes. She measured students' attitudes pre- and post-clinical experiences in two health care settings (nursing home and hospital) and the relationship of knowledge with student attitudes. Scheffler found that there was a positive relationship between knowledge and attitudes. Students' attitudes toward the older adults improved

regardless of their clinical setting; the key was student knowledge acquired as a result of content and experiences with older adults.

Fox and Wold (1996) examined baccalaureate students' perceived learning and attitude changes as a result of a senior capstone course in gerontological nursing. Significant improvements in student attitudes followed completion of the course and it was discovered that community-based settings provided more positive experiences compared with institutional care settings.

Consistent with these studies, my respondents reiterated the value of experience with older adults. They also underscored the range of experience that contributes to knowing and understanding care for these individuals. That this experience was considerably beyond the scope of in-school situations is important to bear in mind for curriculum development. Yet, in-school community-based situations certainly did contribute additional opportunity (and challenge) to meaning-making in relation to health care and professional nursing practice. All respondents, with one exception, used examples of community-based experiences that were associated with their clinical practicum assignments in their reflections on how they have come to know and understand care for older adults. This finding is consistent with Fox and Wold's (1996) findings that community-based experiences offer more opportunity for relationship building. These findings bear ongoing consideration in curriculum design to assist students to build upon past and present lived experience, and to nurture relationship building.

Summary

The two research questions considered in this analysis were:

1. How do baccalaureate nursing students come to know and understand care for older adults?

2. Based on the nature of perceptions and existing literature, what teaching methods / tools might best nurture baccalaureate nursing students' coming to know and understand care for older adults?

The emergent themes provided insights for both research questions as the respondents reflected upon context and experiences that offered opportunities to learn ways of being with older adults. These opportunities represented a constellation of influences that contributed to how students came to know and understand care for these individuals. The students reflected upon multiple patterns of knowing the older adult and engaged in transpersonal caring relationships with them. These opportunities were grounded in experiences that provided the students with possibilities to reflect on the meaning the experience had for them as caregivers, and for their older adult patients as unique individuals. For these nursing students, this reflective thinking incorporated the life experiences they brought to their education as well as the experiences afforded them through their nursing education. Fundamentally these opportunities allowed students to reflect on each experience in isolation and react to that individual circumstance. In addition, students alluded to using these experiences to build a repertoire to assist in contextualizing situations and considering other possibilities. These experiences were the foundation for the students' construction of ways of knowing and ultimately learning the art of caring for older adults.

In Chapter Five I will interpret this study by addressing each of the original research objectives. Specific recommendations to inform nursing curriculum development will be included.

CHAPTER FIVE

INTERPRETATION AND RECOMMENDATIONS

Introduction

In Chapter Four the emergent themes were analyzed in light of the research questions presented in Chapter Two. Findings were also analyzed in relation to previous research / theory derived from the literature in related fields. Similarities and differences in the findings were discussed through the integration of ideas from the literature. The analysis in Chapter Four was an examination of the study findings looking for what Stake (1988) referred to as patterns of meaning. In this chapter I will interpret the patterns of meaning from Chapter Four and make recommendations associated with these interpretations. Regarding the connection between analysis and interpretation, Wolcott (1994) noted that analysis, in the restricted sense is tethered to the data base; "it can float above but must not drift far away. Links to the data must be apparent and strong"...however "Interpretation can soar high overhead, mere threads connecting it to its origins" (p. 264). The intent of this interpretation is to challenge nurse educators to consider new possibilities in teaching and learning care for older adults. The interpretation offered in this final chapter will address the research objectives from Chapter Two as an organizing framework. This chapter will include specific recommendations to inform nursing curriculum development.

Research Objectives and Interpretive Statements

Relocating the original objectives at this point serves as a reminder of the original purpose of this study. What meaning does the thematic analysis hold for nursing education regarding care for older adults? What insights have been brought to focus as a result of this work? What do these students' voices have to

say to contemporary nursing education and professional nursing practice? Interpretive response to each of the research objectives follows.

(1) Describe how baccalaureate nursing students come to know and understand care for older adults.

The pattern of meaning represented by the emergent themes supports established feminist pedagogy in that life experience, relationships, and multiple ways of knowing pervade. The students in this study came to know and understand care for older adults by constructing knowledge based on a variety of lived experiences within a variety of contexts. Often times these experiences began in childhood within the web of family relationships. Family and other out-of-school life experiences provided significant foundation for these students that they readily used as a frame of reference as they engaged in their nursing education. These findings are consistent with Belenky et al. (1986) who found that out-of-school experiences were their respondents' most powerful learning situations. We in nursing education must be mindful that students' lived experiences are a wealth of knowledge to be mined by the student as well as by their nursing education colleagues--faculty as well as peers. Students must be encouraged to reflect upon their life experience as a valuable resource for knowing. This resource is often unperceived until students are challenged to make meaning of it within the framework of new ideas, perspectives, and theories. Students must also take advantage of their faculty and peers' life experiences to expand and enrich their perspective. Students must be supported in drawing upon all these experiences as opportunities to enhance their knowledge construction and meaning-making.

So how do school-related experiences contribute to how students come to know and understand care for older adults? In this study, a variety of school-

related experiences added to the students' knowledge base although certain conditions seemed to foster their knowledge building and personal knowing more forthrightly. Wilson (1993), referring to context for adult learning, noted that adults learn "in" experience as they act in situations and are acted upon by situations. In this study, situations these respondents readily described were those opportunities that allowed for relationship building. In these situations students were actively engaged with the patients over a period of time. In addition, these situations were frequently in a community setting in which the students acted and were acted upon. Students came to know care for the older adult by coming to know the person, him or herself, over time--as a person with AIDS, or with profound hearing loss, or dementia, or impaired mobility as a result of a stroke, or with no living relatives, or imprisoned by their own home. Most critically, students came to know the older adult as a person and as a unique individual. In this study, baccalaureate nursing students came to know and understand care for older adults through connections made within their life experiences and through relationships, developed in and out of school, primarily in community settings. This interpretation of how these students came to know and understand care for older adults leads to the challenge of the second objective.

(2) Describe significant aspects of the nursing student's way of being that influences how they come to know and understand care for older adults.

The pattern of meaning represented by the emergent themes reflects the value students give to life experience, relationships, and being open to multiple ways of knowing. This pattern of meaning offers a glimpse at the significant aspects of these respondents' ways of being that provided the foundation for how they have come to know and understand care for older adults.

These students' reflections conveyed that they are relational beings. While the literature as formal didactic had an influence on their knowing regarding care for older adults, their "ways of being" as a means of knowing was much more significant to them in that their stories of relationship building and making connections dominated their reflections. These "ways of being" included relationship building, taking the time to get to know people and listening to them, making connections, and trying to understand or empathize with their circumstances. These students were engaged in multiple ways of knowing; seeking out aspects to enhance their personal and esthetic knowing. This knowing included relationship building as well as drawing upon past experiences to frame or reframe their way of being, and attempting to understand and empathize with the patient and their family.

Ways of Being as a Means of Knowing

What dominated the data in this study was not a focus on empirical, factual patient assessment and description, and / or application of technical skills. Rather, what did dominate the data was an endeavor to know esthetically and personally the patient as a person. This "being with" the person and establishing a trusting relationship was important "doing," sometimes as an end point in itself, other times as a means to determine the most individualized way to guide the student in her caring responses to the older adult. Boykin and Schoenhofer (1993) refer to this "being with" as authentic presence or "one's intentionally being there with another in the fullness of one's personhood" (p. 34). In describing this way of being, these authors refer to Mayeroff's (1971) "caring ingredients" including openness to the other, reaching out to make connections, honesty, trust, patience, knowing (explicit and implicit), humility, hope, and courage. This authentic presence is what

Margaret referred to as being "exquisitely present" with Shirley, her patient with dementia. Margaret talked about "living in the moment, fear or not, and having the courage to face one's own emotions," in this case, in relation to caring for a challenging patient.

The omission of the respondents' reference to empirical knowing is an interesting observation and one that must not be overlooked. This omission could represent a lack of understanding of approaches to empirical knowing with older adults. It could also represent a de-emphasis of this aspect of care. However, what seems a more likely possibility to me is that for these recent graduates, assessment to support empirical knowing was considered tacit knowledge. The respondents' reflections did not emphasize this implied knowledge as they instead attempted to focus their responses on my questioning that piqued their convergent thinking regarding what was "most important" and "most helpful" in coming to know and understand care for older adults. The empirical factual patient assessment, description, and / or application of technical skills was implied; it was inherent in comprehensive care and viewed as secondary when considering what was "most important" in coming to know and understand care for these people as unique individuals.

Ways of Being as a Reflection of Esteem

Another aspect of the student's way of being that influenced how they came to know and understand care for older adults was their "ways of being as a reflection of regard" or esteem for the older adult. Students conveyed their feelings about: recognizing the uniqueness of older adults' needs, being respectful, patient, open and accepting of them, being willing to learn from the older adult, being open to the strength and potential that older adults have, recognizing their need for

autonomy and independence, and the need to be their advocate. This way of being was not a means to an end, it was the end in itself. These respondents were conveying yet another way of knowing. Carper (1978) refers to ethical knowing as that component of nursing focused on matters of obligation or what ought to be done. It is based on different philosophical positions regarding what is good and what is right. This knowing has its roots in the students' cognitive moral development. Kohlberg's (1976) traditional sense heightens our awareness of the stage of principled moral development in which the student reasons. However, Gilligan's (1982) feminist perspective reminds us that the care and obligation voice often struggles with the traditional justice and rights voice that Kohlberg's stages presume. The students conveying their way of being as a reflection of esteem connotes the care voice, yet their struggle with finding a voice to advocate for patients, or understanding the true need for patient autonomy, despite the risks it may hold, reflects their struggle with the justice voice.

Another consideration with reference to nursing students' ethical knowing is the redefinition of care that occurs with maturity. With changes in maturity, care is redefined with an increasing distinction between helping and taking care of others for approval, and the ethic of responsibility which Gilligan (1982) noted can become a "self chosen anchor of personal integrity and strength" (p. 171). The responsibilities inherent in relationship building imply an obligation to care that may create a struggle in the nursing students' evolving way of being between what "ought to be done," and what "is done," and how to include in the network of care "not only the other but also the self" (Gilligan, 1982, p. 173). Respondents in my study discussed ways of being with older adults as a reflection of esteem. These ways of being conveyed how students felt older adults "should be" treated: with

respect, acceptance, and patience; yet these students did allude to feelings of lack of patience, frustration, and confusion related to observations of others' role modeling lack of patience and respect. Recognizing and working through this dissonance is a necessary challenge in the moral development of the nursing student.

Student Development and Changes in Ways of Being

This moral development process is ongoing as the ethical pattern of knowing continuously transforms based on experiences in which the student is situated and connecting elements of moral choices that present themselves as new patterns. Caffarella and Barnett (1994) note that those who teach from a constructivist perspective recognize that values are a critical part of inquiry and therefore we must help learners understand what they value and how these values influence and frame the learning experience. Students must be assisted in recognizing the ethical nuances of their coming to know and understand care for older adults. Most importantly, the student must engage in genuine experiences with these individuals to know them as people in the context of their lives. In addition, students must be given the opportunity to reflect on these experiences and the ethical dilemmas intrinsic to care situations involving older adults. For example, what are the dilemmas inherent in an older adult's determination to remain independent and living alone in their home? What are the many ethical issues involved in care for an individual with Alzheimer's Disease and her / his aging husband / wife? Students must "try on" caring for these others from different perspectives--their own perspective and their peers' perspectives. They must be given the opportunity to reflect upon their ethical knowing, based on the meaning these experiences have for them, and its implications for their confidence and

comfort in caring for older adults.

Student development theory reminds us of the importance of experiences that both challenge and support the student's growth (Sanford, 1962). Students must be nurtured in the development of confidence and comfort in many ways of knowing and in finding their voice in this process. Students must also be confronted with situations that challenge their abilities and thinking to provide them with the necessary opportunities for growth. Noddings (1984) reminded us of the practical need for teachers to stretch the students' world by presenting an "effective selection" of that world; "to work cooperatively with the student in his struggle toward competence..." (p. 178). Health care delivery is fraught with ethical issues and challenges to our ways of knowing. It readily provides opportunity to "stretch the students' world" and allow possibilities to examine what they value and how these values fit into the framework of competence in the health care delivery world. Care for older adults is no less a part of this challenge and becoming a greater issue daily. Critical questions include: What are appropriate ways to support an older adult's autonomy? What risks are involved in maintaining independence of the frail elderly? In what way should nurses support older adults in their life and death decision-making? Students must be assisted in appreciating this dimension of care and preparing to meet these challenges.

When considering the challenges and supports that facilitate growth it is essential that student readiness must not be overlooked (Sanford, 1962). The opportunity for reflection on situations at different points in the student's development allows for revisiting these situations to take advantage of the experience anew gauged by the student's readiness and maturity. Layers of the depth of the experience may be revealed in response to the students' readiness

and openness to growth provoking challenges and / or sustaining support.

Watson's (1988) Human Care theory of nursing provides another important connecting thread here. According to Watson, a transpersonal caring relationship suggests a special kind of caring relationship, it implies high regard for the whole person and their "being-in-the-world." Watson sees caring in this sense as a moral ideal of nursing "where there is the utmost concern for human dignity and preservation of humanity" (p. 63). Watson's Human Care requires high regard and reverence for a person and human life, nonpaternalistic values that are related to human autonomy, and freedom of choice. Respondents in my study were describing transpersonal caring relationships that they were learning to seek and value as a "way of being" in coming to know and understand care for older adults. How then is this applied to the practice of nursing education? How does this study inform nursing curriculum development? How may these respondents' voices influence nursing care for older adults? These questions lead to the focus of the third research objective.

(3) Describe and discuss the meaning that student perceptions regarding coming to know and understand care for older adults have for baccalaureate nursing curriculum.

In this study context and experience were teased apart into two separate yet closely linked themes. Attention was given to what kinds of experiences the students referred to as well as where those experiences occurred. The significance of recognizing the value of the out-of-school experience has already been established. What then is the complementary value of the in-school experience? This simplistically naive question is meant to cause the nurse educator to "start over" in her or his thinking about what is important in supporting

the student in coming to know and understand care for older adults.

The students' in-school experience is an opportunity to build upon what they bring to their nursing education. Regarding care for the older adult, it is critical to note that many of the respondents' reflections were grounded in community-based experiences (as opposed to traditional in-hospital experiences). Once again the themes converged to support the relational knowing and / or value of relationships in supporting as well as challenging the students' knowledge building. Respondents discussed the importance of ways of being in coming to know and understand care for older adults. These ways of being resounded relationship building. This relationship building specifically focused on: developing a relationship, getting to know older adults, listening, making connections, and trying to understand and / or empathize with the older adult patient. The context that best supported this relationship building was community based experiences.

The dynamics of this pattern serve many purposes of which nurse educators must be mindful. Getting to know the patient is vital for attuned clinical judgments and decision-making. Students were vigorous and clear in this message: Cultivating individual relationships was essential in coming to know and understand care for older adults. This is consistent with previous nursing research done regarding ways of knowing (Carper, 1978; Eyres, Loustau & Ersek, 1992; Beck, 1995) and decision-making (Benner, 1991; Jenny & Logan, 1992; Jenks, 1993; Kosowski, 1995). This knowing and critical decision-making emerges once again in the care for older adults and as such extends the literature into a new setting. The vast array of health care challenges addressing the aging population requires a comprehensive approach to nursing care to say the very least and yet often the challenge of care for older adults is not met with the same enthusiasm that

other specialties such as neonatal intensive care or emergency care inspires. Not only are older adults faced with many physical care needs such as chronic disease and the loss of mobility, vision, or hearing, they are also often faced with the challenge of changes in their lives as a result of psychosocial losses such as retirement, changes in living arrangements, the ability to be independent, and the loss of significant others. To insure comprehensive health care delivery for older adults, students must be given the opportunity to know these patients as people with all the depth and breadth their lives hold.

How can this "knowing" be fostered in the academic setting? The following recommendations are strategies based on the plausible connections I have made between the emergent themes.

(a) Facilitate situations that foster relationship building.

Community-based experiences where the student is able to meet the older adult within their usual context allows the student a larger palette from which to understand the shades and textures of the individual. Seeing the individual as they are in their world offers the student the opportunity to sensitize to the nuances of that person, particularly over time. This element of time is also important in facilitating situations that foster relationship-building. Relationships take time to develop and relationships reveal the depth and complexity of individuals. Questions to be answered include: How is this individual's experience similar or different than others this student has known? What meaning does this patient's health concern have for them? What is important to them? What do they want help with? What are their resources? Who or what is their support system? What will facilitate their well-being?

Sensitizing to these nuances contributes to the student's repertoire of

knowing with reference to this patient and can ultimately benefit both the older adult receiving care and the student as the caregiver. This "knowing" supports the successful caregiving interactions that Kramer (1993) regards as positive relationship-focused coping. The student, as the caregiver, is supported in creating a successful, knowledgeable approach to the older adult by means of enhancing the understanding of this person through relationship building, making connections, and empathizing with the individual receiving care. The realities of acute care settings were used by the respondents as ready examples of "lack of time" and guilt for not "taking the time" to individualize care due to staffing constraints. If this is the reality of the present acute care setting, we must look to other settings that will foster confidence and comfort in clinical judgments and decision-making based on authentically knowing the patient.

For the beginning nursing student, a semester long opportunity to develop a relationship with an older adult in a community setting would provide a foundation on which to build from previous life experiences. This relationship opportunity, as clinical practicum, would evolve over the span of a semester. This relationship building must be fortified with knowledge sharing in faculty-student group dialogues to explore practice issues such as: development of techniques in relationship-building, what being "cared for" means to the student, how caring is communicated, what students can expect of their patients and of themselves in the reciprocal conditions of the one-caring and the one-cared-for. Students also need the opportunity to reflect on how this relationship changes over time--how is it different than it was a week or a month ago and what is the inherent process of this change? Building on this enriched foundation, students more advanced in their nursing education could direct their focus on the realities of fine tuning relationship

building over shorter periods of time in a variety of contexts to adjust to the realities of practice situations. Again these situations must include routine opportunities for reflection in dialogue with faculty and student groups for knowledge sharing and consideration of possibilities. These process suggestions lead to a second strategy recommendation.

(b) Facilitate situations that allow for active engagement and knowledge sharing.

Belenky et al. (1986) encourage us as teachers to focus on the student's knowledge and engage them in the process of thinking in an open dialogue between the teacher and the student. They suggest that through this cyclical dialogue the student and teacher roles merge. We in nursing education must acknowledge we have much to learn from each other. The many and varied life experiences these respondents brought to their nursing education represents similar learning resources that all students bring with them. The richness of diverse groups--diverse in age, family background, experience, meaning-making, and values, is a resource we must be sensitive to, fully acknowledge, and use. Students must be actively engaged and assisted in being open to the knowledge and experience each has to offer. This attitude fosters support for intergenerational knowing that addresses the depth and breadth of student-student, student-faculty, and student-patient relationships.

Knowledge sharing creates an environment that invites engagement and openness to reciprocal participation. Westberg and Jason (1996) note that since there is something to be learned from every patient, when peers jointly review their patient care experiences they multiply their opportunities for learning. Students can learn from reflecting on the steps their peers took, the outcomes of those

actions, and consideration of future possibilities.

Knowledge sharing also offers opportunity for colleagueship in the learning environment and creates a context that conveys the value and worth of each person's knowing. Knowledge sharing establishes the responsibility to and for each other that is collegial. This colleagueship must be nurtured throughout the student's education to establish this relational norm for professional nursing practice. Being open to multiple perspectives offers new possibilities..."I've never thought about it that way before"... What potential for transformational learning? What opportunity for knowledge construction? What possibilities for growth?

(c) Facilitate situations that allow for reflection on action and reflection in action to nurture the development of a mindful, reflective practitioner.

With this suggestion I am reminded of Kolb's (1984) comment that experience not reflected upon is unrealized learning. Reflection is a method to support knowledge construction and must occur to allow reframing and transformational learning. Bevis and Murray (1990) encourage student engagement in open dialogue between the student and the teacher. The intent of this dialogue is exploration, discovery, insight, and a richer grasp of complex issues. Opportunities for such dialogue may occur in small groups, one to one, or in written form through the use of reflective journaling. Such written dialogue can help the reluctant student with a silent voice to entertain discussion with the faculty, in the privacy of the journal, and to begin to build a trust in their existing knowledge that has emerged from their own life experiences. Reflection is the opportunity for the learner to make meaning of their own experiences by formally thinking about those prior experiences and viewing them through a different lens.

Reflection-in-action challenges assumptions about the student's work or

activity while they are doing it, critically examining their present time actions and testing alternatives that reshape what they are doing while they are doing it (Schon, 1987). Students must be encouraged to become comfortable with open dialogue with each other--each in a teacher and learner role--to discuss each other's perspectives on issues and to develop what Wegner (1978) calls a reflective habituation. The habit of reflection and problem-posing would help the practitioner stay attuned to the ever changing health care delivery system. Posing the problem: "What meaning does this specific patient care situation have for the health care delivery system in general?" supports an ever broadening view. This perspective would better allow for consideration of social responsibility and the world as context. With this way of being as common practice, the nurse could comfortably and confidently look to her or his colleagues for critical reflection to support the ongoing cycle of meaning formation and mindful practice.

Reflection-on-action causes the learner to look back on action already taken, critically analyze reasoning and data, and evaluate by testing the action that results in forming a new perspective for future action (Schon, 1987). Much of what was said above regarding reflection-in-action applies to reflection-on-action also, however with the strategy of written reflection or journaling / narrative, comes the opportunity for a very personal dialogue between the learner and herself / himself and / or the intended reader. By the very act of putting thoughts down on paper, the student is compelled to view the experience through the lens of hindsight and can transform the reminiscence into meaning-making, particularly if challenged to do so. Again, this draws upon application of student development theory and the concepts of challenge, support, and readiness (Sanford, 1962).

The written reflection-on-action may facilitate uncovering of layers in the

depth of the student's clinical experience. The student may return to a situation, such as an interaction with a dementia patient, and reflect upon the meaning this experience had for them. Students may reflect upon what challenged them about this experience. They could consider what supported their confidence and comfort in care for older adults, and what new meaning they gained in relation to themselves as caregivers and the well-being of this patient and / or family. This differentiation of the pieces of the experience and the reintegration of them to a new whole promotes assimilation. Once again, what potential for transformational learning? What opportunity for knowledge construction? What possibilities for growth? And perhaps one final question that leads to the last research objective: What influences practice goals to ultimately awaken a passion for nursing care for older adults?

(4) Describe and reflect upon the meaning of student perceptions related to their caregiving expectations and practice goals.

The respondents' reflections indicated that knowing older adults made a difference in their attitude toward care of these individuals. This "knowing" refers to a way of being that nurtures a transpersonal caring relationship. Once again the essence of the four emergent themes converged to address this last research objective. The pattern of meaning represented by these themes indicated that student confidence, resulting from a valued and useful range of life experiences, relationships, and ways of knowing, related to their caregiving expectations and practice goals. Nursing education can make a difference in practice reluctance related to care for older adults. Fostering "knowing" through relationship building challenges ageism (Butler, 1993) and supports inclusive intergenerational knowing. Nursing education must be dedicated to assisting students in increasing

their confidence and comfort in comprehensive care for older adults. Nurse educators must be vigilant of baccalaureate nursing curricula to monitor and enrich its design to acknowledge these issues and to be truly inclusive. A multidimensional focus on "knowing the older adult patient" would address these concerns and entice interest in caring for older adults.

It is indeed possible that this approach to "knowing the patient" could be a model for inclusive practice in the broader context of health education and the health care delivery system as a whole. However, these research interpretations raise several prospective issues. One issue is the value given to reflective practice. Is the demand for efficiency within the current health care delivery model compatible with the reflective practice ideal? Further study of reflective practice in the clinical arena would be useful in the development of a standard for reflective practice. Another issue is the care and / or justice perspective within nursing education specifically, as well as the health care delivery system in general. How can the health care delivery system, which is seemingly grounded in the justice perspective, be inclusive of a care model in practical application? Future study, with a specific focus on the justice and care perspective within nursing education could provide useful insights to further inform nursing curricula. In addition, research focused on the justice and care perspectives within the broader health care delivery system could address issues of inclusivity and marginalization in this health care context. Such studies could contribute significant findings related to the contemporary moral voices in health care which would have implications for all practice arenas.

Conclusion

Returning to the respondents' voices, I noted what these students liked most about caring for older adults. These students' responses were powerful in acknowledging the enjoyment they experienced in talking with older adults, getting to know them, and developing a relationship with them. These students talked about "coming to their level" and perhaps "slowing down" to attune to detail, experiencing the genuineness of that relationship, and often experiencing a reciprocal caring and "good feeling" that comes from knowing you've "made that connection." These students were clear that, if allowed the opportunity, there can be, and is, much to be gained in caring for older adults. And what about their feelings about caring for these individuals?

> Karen: (Regarding her feelings about caring for older adults...) They really touched my heart. I think it might be because of their need to express themselves...I felt like they cared about me as much as I cared about them.
>
> Leigh: I guess my feeling for caring for older adults is, I know that it's something that's in my future, just because that's the nature of nursing...but I really don't see myself in the institution...I don't want to work in a nursing home.
>
> Jody: I enjoy (older adults)...something I would probably do in my career is work with older people...
>
> Kim: (Working with older adults) is definitely my focus of what I want to do...I don't really have a specific unit in mind...but that's definitely who I want to work with.
> Anne: When I went to school three years ago, my main objective was to work with newborns, that was always my goal. As I went through school, I had more opportunities to deal with older adults...I really bonded with them and ...now I'm thinking more about working with older people.

Fostering relationship building with patients, drawing upon one's own and others' lived experiences in collegial sharing, situating in-school experiences in a

context that allows for knowing the patient over time, and nurturing reflective practice can support a sensitivity and enthusiasm for care of older adults which can and will touch us all.

> Relationships change us, reveal us, evoke more from us.
> We do not live in a world that encourages separateness.
> Only when we join with others do our gifts become visible,
> even to ourselves.
>
> Wheatley and Kellner-Rogers (1996, p. 67)

And what are the gifts that are revealed by relationships created in the context of caring for older adults?

These gifts include knowing ourselves within an intergenerational context that may be a new perspective: a new way of viewing relatives, friends, and experiences to make meaning within nursing practice and life; an opportunity for transformational learning and growth.

These gifts include an opportunity to glean the wisdom of others who have the benefit of a wider vista of life perspective, by listening and understanding, by making connections, by gaining empathy, and / or by coming to appreciate the strength and potential in aging.

These gifts include understanding need from a new perspective: a perspective of all-encompassing drive to remain independent and live autonomously, a need for purpose and sense of well-being, a need for security and safety, a need for respect, and a need to be trusting and trustworthy.

These gifts include making a difference through advocacy and presence, through being with and caring-for, as well as being the one-cared-for.

These gifts include opportunity to share and construct knowledge by joining with other students, other faculty, and other patients, all teachers and all learners,

to expand the web of connection and better embrace a view of all the possibilities that life, including aging, has to offer.

APPENDIX A

GENERAL INTERVIEW FORMAT

1. What does "care for an older adult" mean to you?
2. Looking back over your whole life, can you tell me about a really powerful learning situation that you've had, in or out of school, related to care for older adults? What meaning did this have for you?
3. In your learning about care for older adults, have you come across an idea that made you see things differently?
4. What has been most helpful to you in coming to know and understand care for older adults?
5. Are there things that you haven't learned (in school) that are important to you related to care of older adults?
6. How have you come to know how to care for older adults?
7. What feelings do you have about caring for older adults?
8. What is important to you in caring for an older adult?
9. What do you like most and least about caring for older adults?
10. Tell me about a time when you came away from a care situation with an older adult thinking "I'm never going to forget this situation because....."
11. What are some of the issues related to care for older adults that have affected you?
12. Is there anything else you need to tell me that will reflect how you have come to know and understand care for older adults?

APPENDIX B

INTERVIEW SUMMARY FORM

Investigator: Interview Type:

Respondent Name:

Date of Contact:

Today's Date:

1. What were the main issues or themes revealed in this interview?

2. Summarize the information obtained on each of the target questions for this contact.

3. What else was salient, interesting, illuminating or important in this contact?

4. What new or remaining questions should be considered in the next contact?

APPENDIX C

DOCUMENT SUMMARY FORM

Investigator:

Respondent:

Date:

Name or description of document:

Event or contact with which document is associated:

Significance or importance of document:

Summary of contents of document:

What were the main issues or themes that struck you in this document?

Questions regarding or generated by the document:

APPENDIX D

HUMAN SUBJECTS FORMS

Information for Review of Research Involving Human Subjects

Iowa State University

(Please type and use the attached instructions for completing this form)

1. Title of Project: Ways of Knowing and Caring for Older Adults: A Qualitative Study of Baccalaureate Nursing Students' Perceptions

2. I agree to provide the proper surveillance of this project to insure that the rights and welfare of the human subjects are protected. I will report any adverse reactions to the committee. Additions to or changes in research procedures after the project has been approved will be submitted to the committee for review. I agree to request renewal of approval for any project continuing more than one year.

Debra Diane Braun Franzen — Typed Name of Principal Investigator

11-19-'97 — Date

Debra Diane Braun Franzen — Signature of Principal Investigator

Grand View College — Department

1204 Grandview Ave., Des Moines, Ia. 50316 — Campus Address

515-263-2859 — Phone Number to Report Results

3. Signatures of other investigators

Signatures of other investigators	Date	Relationship to Principal Investigator
Florence A. Hamrick	Nov. 21, 1997	Major Professor

4. Principal Investigator(s) (check all that apply)
☐ Faculty ☐ Staff ☒ Graduate Student ☐ Undergraduate Student

5. Project (check all that apply)
☐ Research ☒ Thesis or dissertation ☐ Class project ☐ Independent Study (490, 590, Honors project)

6. Number of subjects (complete all that apply)
6 # Adults, non-students ___ # ISU student ___ # minors under 14 ___ # minors 14 - 17 ___ other (explain)

7. Brief description of proposed research involving human subjects: (See instructions, Item 7. Use an additional page if needed.)
See additional page.

(Please do not send research, thesis, or dissertation proposals.)

8. Informed Consent:
☒ Signed informed consent will be obtained. (Attach a copy of your form.)
☐ Modified informed consent will be obtained. (See instructions, item 8.)
☐ Not applicable to this project.

9. Confidentiality of Data: Describe below the methods to be used to ensure the confidentiality of data obtained. (See instructions, item 9.)
Participant confidentiality will be maintained through the use of pseudonyms to represen respondents and their transcripts. In addition, respondents will be given the opportuni to view a draft of the final report prior to dissemination to demonstrate that anonymity was maintained.

Confidentiality of data will be maintained through:
storage of data and notes in a secure location accessible only to the researcher; use of personal and organizational pseudonyms in all written reports and oral presentations of this research; and removal of personally-identfiable information from field notes, transcripts, and research reports submitted to the course instructor.

10. What risks or discomfort will be part of the study? Will subjects in the research be placed at risk or incur discomfort? Describe any risks to the subjects and precautions that will be taken to minimize them. (The concept of risk goes beyond physical risk and includes risks to subjects' dignity and self-respect as well as psychological or emotional risk. See instructions, item 10.)

See additional page.

11. CHECK ALL of the following that apply to your research:

- ☐ A. Medical clearance necessary before subjects can participate
- ☐ B. Administration of substances (foods, drugs, etc.) to subjects
- ☐ C. Physical exercise or conditioning for subjects
- ☐ D. Samples (Blood, tissue, etc.) from subjects
- ☐ E. Administration of infectious agents or recombinant DNA
- ☐ F. Deception of subjects
- ☐ G. Subjects under 14 years of age and/or ☐ Subjects 14 - 17 years of age
- ☐ H. Subjects in institutions (nursing homes, prisons, etc.)
- ☒ I. Research must be approved by another institution or agency (Attach letters of approval)

If you checked any of the items in 11, please complete the following in the space below (include any attachments):

Items A–E Describe the procedures and note the proposed safety precautions being taken.

Items D–E The principal investigator should send a copy of this form to Environmental Health and Safety, 118 Agronomy Lab for review.

Item F Describe how subjects will be deceived; justify the deception; indicate the debriefing procedure, including the timing and information to be presented to subjects.

Item G For subjects under the age of 14, indicate how informed consent from parents or legally authorized representatives as well as from subjects will be obtained.

Items H–I Specify the agency or institution that must approve the project. If subjects in any outside agency or institution are involved, approval must be obtained prior to beginning the research, and the letter of approval should be filed.

Grand View College
1204 Grandview Avenue
Des Moines, Iowa 50316

Last Name of Principal Investigator FRANZEN, Debra
Diane Brown

Checklist for Attachments and Time Schedule

The following are attached (please check):

*12. ☒ Letter or written statement to subjects indicating clearly:
- a) purpose of the research
- b) the use of any identifier codes (names, #'s), how they will be used, and when they will be removed (see Item 17)
- c) an estimate of time needed for participation in the research and the place
- d) if applicable, location of the research activity
- e) how you will ensure confidentiality
- f) in a longitudinal study, note when and how you will contact subjects later
- g) participation is voluntary; nonparticipation will not affect evaluations of the subject

*13. ☒ Consent form (if applicable) Included in 12.

14. ☒ Letter of approval for research from cooperating organizations or institutions (if applicable)

15. ☒ Data-gathering instruments

16. Anticipated dates for contact with subjects:

First Contact	Last Contact
Dec. 1997	July 1998
Month / Day / Year	Month / Day / Year

17. If applicable: anticipated date that identifiers will be removed from completed survey instruments and/or audio or visual tapes will be erased:

Sept. 1998
Month / Day / Year

18. Signature of Departmental Executive Officer — Date — Department or Administrative Unit

11/3/97

19. Decision of the University Human Subjects Review Committee:

☒ Project Approved ___ Project Not Approved ___ No Action Required

Patricia M. Keith — 12-2-97 — Signature of Committee Chairperson
Name of Committee Chairperson — Date

Note * Potential respondents will first be contacted by phone. The consent form will be mailed to respondents prior to the first data gathering session.

GC: 8/95

Information for Review of Research Involving Human Subjects

Title of Project: Ways of Knowing and Caring for Older Adults: A Qualitative Study of Baccalaureate Nursing Students' Perceptions
Principal Investigator: Debra Franzen

7. Brief description of proposed research involving human subjects.

The purpose of this study is to explore how baccalaureate nursing students come to know and understand care for older adults and in turn apply this student perspective to practice issues related to gerontology nursing. Knowledge gained from exploring this perspective can inform baccalaureate nursing curriculum development in gerontology and impact comprehensive health care delivery for an aging population. A qualitative approach using interview and document analysis will be employed.

Six participants will be recruited from the most recent graduates of a baccalaureate program of studies in nursing. The recent graduates will be requested to meet with me individually for two separate sessions during which I will conduct a semi-structured interview based on the attached format. In addition, I will be requesting that the respondents provide me with a variety of their previously developed learning tools such as concept papers, journals, and care plans as additional data sources for document review. The decision regarding type and number of documents the respondent selects to share with me will be their choice although I will encourage them to provide as many documents as they can to assist me in achieving depth of document review. Since I am a faculty member at the institution where I propose to do this study, a conscious decision was made to recruit students post graduation to avoid the possibility of respondents perceiving a school related coercion associated with their participation and their interview responses.

10. Risks, measures of respect, and benefits.

I do not anticipate any risk associated with participation in this study. At all times respondents will be treated with dignity and respect.

I believe that listening to the respondents' stories and providing an opportunity for reflection will be perceived as a valued experience for these recent nursing graduates and a benefit of participation. I would anticipate that the opportunity to receive feedback and a final report would also be perceived as a benefit of participation in this study.

Research Consent Form

You are invited to participate in a research study on how baccalaureate nursing students come to know and understand care for older adults. This research is my dissertation which is part of my doctoral studies in Professional Studies in Higher Education at Iowa State University.

For the purposes of data collection, you will be asked to participate in two interviews scheduled at your convenience. These interviews will be documented through use of audiotape and researcher notes. The interviews will each last approximately one hour. In addition, I will ask you to provide any written documents you have developed during your experience as a nursing student which may demonstrate your care for an older adult. You will also be invited to provide feedback on preliminary research results.

Your participation is confidential and will be maintained through: storage of data and notes in a secure location accessible only to the researcher; use of personal and organizational pseudonyms in all written reports and oral presentations of this research; and removal of personally-identifiable information from field notes, transcripts, and research reports submitted to the course instructor.

There are no foreseeable risks or discomforts to you as a participant in this study. Your participation in this research will be a valuable contribution to nursing curriculum development and care for older adults. Participation in this study is voluntary and you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time. If you withdraw from the study, I will destroy the transcripts and field notes of your data or give these documents to you. In addition, any documents that you provide and any copies made of them will be returned to you.

If at any time you have questions about this research or your participation, you may contact me at: Debra Franzen, Grand View College, 1200 Grandview Avenue, Des Moines IA 50316; 263-2859. You may also contact my major professor, Dr. Florence Hamrick, at: N232 Lagomarcino, Iowa State University, Ames, IA 50011; 294-9628; fhamrick@iastate.edu.

I consent to participate in the research study named and described above.

Name: (printed) _____

Signature: _____ Date: _____

General Interview Format

1. What does "care for an older adult" mean to you?
2. Looking back over your whole life, can you tell me about a really powerful learning situation that you've had, *in or out of school, related to care for older* adults? What meaning did this have for you?
3. In your learning about care for older adults, have you come across an idea that made you see things differently?
4. What has been most helpful to you in coming to know and understand care for older adults?
5. Are there things that you haven't learned (in school) that are important to you related to care of older adults?
6. How have you come to know how to care for older adults?
7. What feelings do you have about caring for older adults?
8. What is important to you in caring for an older adult?
9. What do you like most and least about caring for older adults?
10. Tell me about a time when you came away from a care situation with an older adult thinking "I'm never going to forget this situation because....."
11. What are some of the issues related to care for older adults that have affected you?
12. Is there anything else you need to tell me that will reflect how you have come to know and understand care for older adults?

GRAND VIEW COLLEGE
1896 - 1996

November 17, 1997

Debra B. Franzen
Associate Professor of Nursing
Division of Nursing
Grand View College
Des Moines, Iowa 50316

Dear Ms. Franzen,

The President's Council met and reviewed your proposal for research on how baccalaureate nursing students come to know and understand care of older adults. In addition, we reviewed the research consent form and the general interview format. We are in agreement that you may proceed with the research using Grand View College Nursing students and graduates.

We wish you the best in completing your dissertation and doctoral studies and look forward to seeing the results of your research.

Sincerely,

Ferol S. Menzel

Ferol S. Menzel, Ph.D.
Director of Planning and Institutional Research

Phone Script for Contacting Potential Respondents

Hello (Name of potential respondent):

This is Debra Franzen. I'm calling to invite you to participate in a research study on how baccalaureate nursing students come to know and understand care for older adults. This research is my dissertation which is part of my doctoral studies in Professional Studies in Higher Education at Iowa State University.

The purpose of this study is to explore how baccalaureate nursing students come to know and understand care for older adults and in turn apply this student perspective to practice issues related to gerontology nursing. I hope to use knowledge gained from exploring this perspective to inform baccalaureate nursing curriculum development in gerontology and impact comprehensive health care delivery for an aging population. I will be using a qualitative approach for my research which will include interview and document analysis.

If you choose to participate in this study, I will be requesting to conduct two interviews with you for the purposes of data collection. These interviews will be scheduled at your convenience and will each last approximately one hour. Each interview will be documented through use of audiotape and researcher notes. In addition, I will ask you to provide any written documents you have developed during your experience as a nursing student which may demonstrate your care for an older adult. You will also be invited to provide feedback on preliminary research results.

Your participation will be confidential and will be maintained through: storage of data and notes in a secure location accessible only to the researcher; use of personal and organizational pseudonyms in all written reports and oral presentations of this research; and removal of personally-identifiable information from field notes, transcripts, and research reports submitted to the course instructor.

There are no foreseeable risks or discomforts to you as a participant in this study. Your participation in this research will be a valuable contribution to nursing curriculum development and care for older adults. Participation in this study is voluntary and you may decline to participate without penalty. If you decide to participate, I will subsequently mail a consent form to you to be signed prior to the first data gathering session. You may withdraw from the study at any time. If you withdraw from the study, I will destroy the transcripts and field notes of your data or give these documents to you. In addition, any documents that you provide and any copies made of them will be returned to you.

Do you have any questions regarding this invitation to participate?

Would you be willing to participate in this opportunity?

Thank you.

APPENDIX E

RESERCH CONSENT FORM

You are invited to participate in a research study on how baccalaureate nursing students come to know and understand care for older adults. This research is my dissertation which is part of my doctoral studies in Professional Studies in Higher Education at Iowa State University.

For the purposes of data collection, you will be asked to participate in two interviews scheduled at your convenience. These interviews will be documented through use of audiotape and researcher notes. The interviews will each last approximately one hour. In addition, I will ask you to provide any written documents you have developed during your experience as a nursing student which may demonstrate your care for an older adult. You will also be invited to provide feedback on preliminary research results.

Your participation is confidential and will be maintained through: storage of data and notes in a secure location accessible only to the researcher; use of personal and organizational pseudonyms in all written reports and oral presentations of this research; and removal of personally-identifiable information from field notes, transcripts, and research reports submitted to the course instructor.

There are no foreseeable risks or discomforts to you as a participant in this study. Your participation in this research will be a valuable contribution to nursing curriculum development and care for older adults. Participation in this study is voluntary and you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time. If you withdraw from the study, I will destroy the transcripts and field notes of your data or give these documents to you. In addition, any documents that you provide and any copies made of them will be returned to you.

If at any time you have questions about this research or your participation, you may contact me at: Debra Franzen, Grand View College, 1200 Grandview Avenue, Des Moines IA 50316; 263-2859. You may also contact my major professor, Dr. Florence Hamrick, at: N232 Lagomarcino, Iowa State University, Ames, IA 50011; 294-9628; fhamrick@iastate.edu.

I consent to participate in the research study named and described above.

Name: (printed) _____

Signature: _____ Date: _____

Researcher Signature: _____ Date: _____

APPENDIX F

DEFINITIONS OF DATA ORGANIZATION DIVISIONS

According to Marshall and Rossman (1995), "Data analysis is the process of bringing order, structure, and meaning to the mass of collected data" (p. 111). The following definitions depict how the data in this study were organized.

Unit: A unit is the smallest piece of information about something that can stand by itself (Lincoln & Guba, 1985). In the initial "tearing down" of the respondent transcripts, narrative was sorted into units. This divergent process was an approach to discover as many specific raw units of information as possible. Ultimately, the units served as the basis for category definition.

Category: A category is a grouping of units that has internal convergence and external divergence (Guba, 1978). Categories should be internally consistent but distinct from one another. In categorization, an attempt is made to identify the salient, grounded categories of meaning, held by participants in the setting (Marshall & Rossman, 1995).

Theme: A theme is the essence of what is represented in the synthesis of connected categories. Creating themes is a convergent process of finding meaning within the categories of data. This process draws the categories together to get a sense of what is "typical" of the phenomenon being studied (Polit & Hungler, 1997).

Pattern: An arrangement; a combination of actions or qualities that always happen the same way or in the same order (Webster, 1984). In this study a pattern represents a reoccurring relationship between categories within a theme. Relationships among categories emerged which remained within the essence of the theme, yet created distinct arrangements in the connection of the categories in that theme.

APPENDIX G

DATA DEPICTED AS CATEGORIES AND PATTERNS WITHIN FOUR THEMES

1. Experience as a Growing Foundation
    - A. Experience to Support a Growing Foundation
        - Experience / Opportunities in General
        - Early Childhood Experience
        - Role Modeling
        - Experience that Nurtured Confidence
        - Experience Over Time
        - Relating Experience to Relatives and Self
    - B. Experience to Challenge a Growing Foundation
        - Understanding Loss and Loneliness
        - Dealing with Death and Grief
        - Personal Feelings of Loss
        - Experience that Shakes Confidence
        - Frustration
2. Ways of Being
    - A. Ways of Being as a Way of Knowing the Older Adult
        - Developing a Relationship
        - Getting to Know Them
        - Enjoying Their Stories (Listening to Know Them)
        - Listening
        - Trying to Understand / Empathizing
        - Making Connections
    - B. Ways of Being as a Reflection of Esteem
        - Recognizing the Uniqueness of Needs
        - Respect
        - Patience
        - Learning from the Individual
        - Acceptance
        - Recognizing Strength and Potential in Aging
        - Promotion of Independence and Autonomy
        - Advocacy
3. Contexts of Care
    - Family
    - Life
    - School
    - Hospital
    - Community
    - Work
    - Nursing Home / Retirement Center
4. Teaching and Learning Care for Older Adults
    - Relationship Building
    - Value of Early Childhood, Family, and Life Experiences
    - Making Meaning

APPENDIX H

ORAL PRESENTATION OF ANALYSIS / INTERPRETATION OF FINDINGS AND RECOMMENDATIONS TO INFORM NURSING CURRICULUM DEVELOPMENT FRAMED WITHIN THE ORIGINAL RESEARCH OBJECTIVES

(NOVEMBER 18, 1998)

(1) Describe how baccalaureate nursing students come to know and understand care for older adults.

Key concepts:

* Life experience
* Relationships
* Multiple ways of knowing

A variety of lived experiences within a variety of contexts was significant including:

* Early childhood experiences within the web of family relationships.
* Family and other out-of-school experiences were also used as a frame of reference.
* School-related experiences:
  - Situations that allowed for relationship building...in which students were actively engaged with the patients over a period of time...where they were acting in and being acted upon in the situation.
  - Community contexts seemed to foster knowledge building, personal knowing, and making connections.
  - Situations in which students were able to come to know the older adult as a unique individual.

Thoughts:

* We must begin with... "What do students know?"

* We must be mindful that students' life experiences are a wealth of knowledge to be mined by the students as well as by their nursing education colleagues--faculty as well as peers.

* Students must be encouraged to reflect upon their life experiences as a valuable resource for knowing.

* This resource is often unperceived until the students are challenged to make meaning of it within the framework of new ideas, perspectives, and theories.

* Students must also take advantage of their faculty and peers' life experiences to expand and enrich their perspective...to enhance their knowledge construction and meaning-making.

(2) Describe significant aspects of the nursing students' way of being that influences how they come to know and understand care for older adults.

(a) "Ways of being as a means of knowing" was meaningful to these students. These multiple ways of knowing older adults included:

* relationship building
* taking the time to get to know people and listening to them
* making connections
* trying to understand or empathize with their circumstances

"Being with" the person and establishing a trusting relationship was important "doing,"

- sometimes as an end point in itself,
- other times as a means to determine the most individualized way to guide caring responses [Mayeroff's (1971) caring ingredients; Carper's (1978) ways of knowing; Boykin & Schoenhofer's (1993) authentic presence].

(b) "Ways of being as a reflection of esteem" depicted:

* Ethical knowing [Carper (1978) regarding matters of obligation or "what ought to be done."]
* Basis of students' moral development [Kohlbers's (1976) justice perspective; Gilligan's (1982) care and obligation perspective; Noddings' (1984) moral imperative and fundamental relatedness.]
* Watson's Human Care theory (1988) which speaks to care as the "moral ideal of nursing."

The transpersonal caring relationship assumes a set of values which are associated with:

- high regard and reverence for a person,
- nonpaternalistic values that are related to human autonomy,
- freedom of choice.

Students' reflections included feelings about:

* recognizing the uniqueness of older adults' needs
* being respectful
* patience
* being open and accepting of the older adult
* being willing to learn from the older adult
* being open to the strength and potential that older adults have
* recognizing the older adults' need for autonomy and independence
* being the older adults' advocate

Thoughts:

* The development process is ongoing as the ethical pattern of knowing continuously transforms based on experiences in which the student is situated and connecting elements of moral choices present themselves as new patterns.

* Values are a critical part of inquiry and must be acknowledged as such.

* We must help learners understand what they value and how these values influence and frame the learning experience.

* Students must engage in genuine or authentic experiences with older adults to know them as people within the context of their lives.

* Experiences that both challenge and support the student's growth are essential including:

    - Experiences that nurture confidence and comfort in many ways of knowing.

    - Experiences that challenge abilities and thinking to provide them with the necessary opportunities for growth.

        Stretch the students' world by presenting an effective selection of that world (Noddings, 1984).

* Students must be given opportunity to reflect on these experiences and the ethical dilemmas inherent in the older adults' life, to support the transformational learning process.

    - Transformational learning situates learning in the interpretation of the experience by the learner.

    - It is important to reflect on experiences at different points in the students' development...

    - This is the foundation of growth in making meaning.

(3) Describe and discuss the meaning that student perceptions regarding coming to know and understand care for older adults have for baccalaureate nursing curriculum.

Knowing the older adult is vital for attuned clinical judgments and decision-making. This finding is consistent with previous research in other practice areas (Carper, 1978; Benner, 1991; Jenny & Logan, 1992; Eyres, Loustau, & Ersek, 1992; Jenks, 1993; Beck, 1995; Kosowski, 1995).

Recommendations for nursing education:

(a) Facilitate situations that foster relationship-building with patients.

(b) Facilitate situations that allow for connected teaching, active engagement, and knowledge sharing.

Foster intergenerational knowing and colleagueship in open dialogue between:

- patient and student (older adult as teacher)
- student and faculty (reciprocal exchange and valuing each others' knowledge)
- student and student (being open to the richness of diverse groups--diverse in age, family background, experiences, meaning-making, and values).

(c) Facilitate situations that allow for reflection on action and reflection in action to nurture the development of a mindful, reflective practitioner.

Strategies to support knowledge construction and transformational learning:

- problem-posing
- critical analysis
- dialogue
- journaling
- narratives

(4) Describe and reflect upon the meaning of student perceptions related to their caregiving expectations and practice goals.

* Knowing older adults made a difference in students' attitudes toward care of these individuals.

* This "knowing" refers to a way of being that nurtures a transpersonal caring relationship.

* Student confidence, resulting from a valued and useful range of life experiences, relationships, and ways of knowing, is related to their caregiving expectations and practice goals.

* Fostering "knowing" through relationship building challenges ageism and supports inclusive intergenerational knowing.

* These students were clear that if allowed the opportunity, there can be, and is, much to be gained in caring for older adults.

    - Fostering relationship building with patients,

    - Drawing upon one's own and others' lived experiences in collegial sharing,

    - Situating in-school experiences in a context that allows for knowing the patient over time, and

    - Nurturing reflective practice...

...can support a sensitivity and enthusiasm for care of older adults that can and will touch us all.

REFERENCES

Altheide, D. L., & Johnson, J. M. (1994). Criteria for assessing interpretive validity in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 485-499). Thousand Oaks, CA: Sage.

American Nurses Association (1986). Gerontological nursing curriculum: Survey analysis and recommendations. Kansas City, MO: Author.

American Nurses Association (1995). Gerontological nursing curriculum: Survey analysis and recommendations. Kansas City, MO: Author.

Anderson, G. L. (1989). Critical ethnography in education. Review of Educational Research, 59(3), 249-270. [Reprinted in C. Conrad, A. Neumann, J.G. Haworth, & P. Scott (Eds.), Qualitative research in higher education: Experiencing alternative perspectives and approaches (pp. 209-229). ASHE Reader Series. Needham, MA: Ginn.]

Anderson, M. L. (1990). Changing the curriculum in higher education. In C.F. Conrad and J.G. Haworth (Eds.) Curriculum in transition: Perspectives on the undergraduate experience (pp. 119-144). ASHE Reader Series. Needham, MA: Ginn

Atkins, S., & Murphy, K. (1993). Reflection: A review of the literature. Journal of Advanced Nursing, 18, 1188-1192.

Baltes, P. B. (1987). Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline. Developmental Psychology, 23(5), 611-626.

Beck, S. E. (1995). Cooperative learning and feminist pedagogy: A model for classroom instruction in nursing education. Journal of Nursing Education, 34(5), 222-227.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). Women's ways of knowing: The development of self, voice, and mind. New York: Basic.

Benner, P. (1991). The role of experience, narrative, and community in skilled ethical comportment. Advances in Nursing Science, 14(2), 1-21.

Benner, P., Tanner, C., & Chesla, C. (1992). From beginner to expert: Gaining a differentiated clinical world in critical care nursing. Advances in Nursing Science, 14(3), 13-28.

Benner, P., & Wrubel, J. (1989). The primacy of caring: Stress and coping in health and illness. Menlo Park, CA: Addison Wesley.

Berthoff, A. (1987). Dialectical notebooks and the audit of meaning. In T. Fulwiler (Ed.), The Journal Book (pp. 11-18). Portsmouth, NH: Boynton / Cook.

Bevis, E. (1989). Teaching and learning: The key to education and professionalism. In E. Bevis & J. Watson (Eds.), Toward a caring curriculum: A new pedagogy for nursing (pp. 153-185). New York: National League for Nursing.

Bevis, E., & Murray, J. (1990). The essence of the curriculum revolution: Emancipatory teaching. Journal of Nursing Education, 29, 326-331.

Bevis, E., & Watson, L. (Eds.). (1989). Toward a caring curriculum: A new pedagogy for nursing. New York: National League for Nursing.

Beyea, S. C. (1993). Teaching nursing students to assess older clients in the clinical setting. Gerontology & Geriatrics Education, 13(3), 19-72.

Bishop, A. (1990). Nursing education as authentic nursing care. In M. Leininger & J. Watson (Eds.), The caring imperative in nursing education. New York: National League for Nursing.

Bloom, L. R. (1996). Stories of ones's own: Nonunitary subjectivity in narrative representation. Qualitative Inquiry, 2(2), 176-197.

Boykin, A. (1994). Living a caring-based program. New York: National League for Nursing.

Boykin, A., & Schoenhofer, S. (1993). Nursing as caring: A model for transforming practice. New York: National League for Nursing.

Brody, C. M., & Wallace, J. (Ed.). (1994). Ethical and social issues in professional education. Albany, NY: State University of New York Press.

Brody, E. M., & Schoonover, C. B. (1986). Patterns of parent-care when adult daughters work and when they do not. The Gerontologist, 26(4), 372-380.

Brody, C. M., & Witherell, C. (1994). Story and voice in the education of professionals. In C. M. Brody and J. Wallace (Eds.), Ethical and social issues in professional education (pp. 69-87). Albany, NY: State University of New York Press.

Burke, M., & Sherman, S. (Eds.). (1993). Ways of knowing and caring for older adults. New York: National League for Nursing.

Burnside, I. M. (1988). Nursing and the aged: A self-care approach (3rd ed.). New York: McGraw-Hill, Inc.

Butler, R. N. (1993). Dispelling ageism: The cross-cutting intervention. Generations, 17(2), 75-78.

Caffarella, R. S., & Barnett, B. G. (1994). Characteristics of adult learners and foundations of experiential learning. (pp. 29-41) New Directions for Adult and Continuing Education, 62. San Francisco: Jossey-Bass.

Candy, P. C. (1991). Self-direction for lifelong learning: A comprehensive guide to theory and practice. San Francisco: Jossey-Bass.

Carper, B. A. (1978). Fundamental patterns of knowing in nursing. Advances in Nursing Science, 1(1), 13-23.

Carr, K. K., & Kazanowski, M. K. (1994). Factors affecting job satisfaction of nurses who work in long-term care. Journal of Advanced Nursing, 19, 878-883.

Chickering, A.W., & Reisser, L. (1993). Education and identity (2nd ed.). San Francisco: Jossey-Bass.

Clark, M. C. (1993). Transformational learning. New Directions for Adult and Continuing Education, 57, 47-55.

Collard, S., & Stalker, J. (1991). Women's trouble: Women, gender, and the learning environment. New Directions for Adult and Continuing Education, 50, 71-81.

Cooper, J. E. (1994). Digging, daring, and discovering: Sifting the soil of professional life through journal writing. In C. M. Brody and J. Wallace (Eds.), Ethical and social issues in professional education (pp. 103-116). Albany, NY: State University of New York Press.

Darbyshire, P. (1995). Lessons from literature: Caring, interpretation, and dialogue. Journal of Nursing Education, 34(5), 211-216.

Davies, E. (1995). Reflective practice: A focus for caring. Journal of Nursing Education, 34(4), 167-174.

Delaney, E. (1994). The Delaney sisters' book of everyday wisdom. New York: KODANSHA International.

DeLongis, A., & O'Brien, T. (1990). An interpersonal framework for stress and coping: An application to the families of Alzheimer's patients. In M. Stephens, J. Crowther, S. Hobfoll, & D. Tennenbaum (Eds.), Stress and coping in later-life families (pp. 221-239). New York: Hemisphere.

Denzin, N. K., & Lincoln, Y. S. (1994). Introduction: Entering the field of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 1-17). Thousand Oaks, CA: Sage.

Diekelmann, N. L. (1993). Behavioral pedagogy: A Heideggerian hermeneutical analysis and the lived experiences of students and teachers in baccalaureate nursing education. Journal of Nursing Education, 32(6), 245-249.

Diekelmann, N. (1990). Nursing education: Caring, dialogue, and practice. Journal of Nursing Education, 29, 300-305.

Dillon, R. S., & Stines, P. W. (1996). A phenomenological study of faculty-student caring interactions. Journal of Nursing Education, 35(3), 113-118.

Earthy, A. (1993). A survey of gerontological curricula in Canada: Generic baccalaureate nursing programs. Journal of Gerontological Nursing, 19(12), 7-14.

Evans, L. K. (1996). Knowing the patient: The route to individualized care. Journal of Gerontologic Nursing, 22(3), 15-19.

Eyres, S. J., Loustau, A., & Ersek, M. (1992). Ways of knowing among beginning students in nursing. Journal of Nursing Education, 31 (4), 175-180.

Felsen, L. (1993). Gerontologic nursing: Can we make it the first career choice? Geriatric Nursing, 14, 152-155.

Franzen, D. B. (1996). Baccalaureate nursing students coming to know and understand care for older adults. Unpublished manuscript.

Fox, S. D., & Wold, J. E. (1996). Baccalaureate student gerontological nursing experiences: Raising consciousness levels and affecting attitudes. Journal of Nursing Education, 35(8), 348-355.

Fullerton, J. T., Lantz, J., & Quayhagen, M. P. (1992). The level and focus of geriatric nursing content in ADN and BSN programs. Journal of Nursing Education, 31(9), 390-396.

Fulwiler, T. (Ed.). (1987). The Journal Book. Portsmouth, NH: Boynton / Cook.

Gatz, M., Bengston, V., & Blum, M. (1990). Caregiving families. In J. E. Birren & K. W. Schaie (Eds.), Handbook of the psychology of aging (3rd ed., pp. 404-426). San Diego, CA: Academic.

Gaut, D. A. (1983). Development of a theoretically adequate description of caring. Western Journal of Nursing Research, 5 (4), 313-324.

Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. In C. Geertz, The interpretation of cultures (pp. 3-30). New York: Basic Books.

Gilligan, C. (1993). In a different voice. Cambridge: Harvard University Press.

Gioiella, E. C. (1993). Gerontological nursing education in the next millennium. Gerontology & Geriatrics Education, 13(3), 99-105.

Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory. Chicago: Aldine.

Glesne, C., & Peshkin, A. (1992). Becoming qualitative researchers: An introduction. White Plains, NY: Longman.

Gollnick, D. M., & Chinn, P. C. (1990). Multicultural education in a pluralistic society (3rd ed.). New York, NY: Merrill.

Grigsby, K., & Megel, M. (1995). Caring experiences of nurse educators. Journal of Nursing Education, 34(9), 411-417.

Guba, E. G. (1978). Toward a methodology of naturalistic inquiry in educational evaluation (Monograph Series No. 8). Los Angeles: University of California, Center for the Study of Evaluation.

Halloran, L., & Dean, L. (1994). Old for an evening: An experiential game. Journal of Nursing Education, 33(4), 155-156.

Hanson, L. E., & Smith, M. J. (1996). Nursing students' perspectives: Experiences of caring and not-so-caring interactions with faculty. Journal of Nursing Education, 35(3), 105-112.

Henretta, J. C. (1988). Conflict and cooperation among age strata. In J. E. Birren & V. L. Bengston (Eds.), Emergent theories of aging (pp. 385-404). New York: Springer.

Hogstel, M. (1988). Gerontological nursing in the baccalaureate curriculum. Nurse Educator, 13(3), 14-18.

House, E. R. (1990). An ethics of qualitative field studies. In E. G. Guba (Ed.), The paradigm dialog (pp. 158-164). Thousand Oaks, CA: Sage.

Hughes, L. (1993). Peer group interactions and the student-perceived climate for caring. Journal of Nursing Education, 32(2), 78-83.

Jackson, L., & MacIsaac, D. (1994). Introduction to a new approach to experiential learning. New Directions for Adult and Continuing Education, 62, 17-27.

Jenks, J. M. (1993). The pattern of personal knowing in nurse clinical decision making. Journal of Nursing Education, 32(9), 399-405.

Jenny, J., & Logan, J. (1992). Knowing the patient: One aspect of clinical knowledge. Image, 24(4), 254-258.

Johns, C. (1995). Framing learning through reflection within Carper's fundamental ways of knowing in nursing. Journal of Advanced Nursing, 22, 226-234.

Kayser-Jones, J. (1993). Ways of knowing: Research in gerontological nursing. In M. Burke & S. Sherman (Eds), Ways of knowing and caring for older adults (pp. 17-39). New York: NLN Press, Pub. No. 14-2541.

Klein, R. R. (1994). Reflection and adult development: A pedagogical process. In C. M. Brody and J. Wallace (Eds.), Ethical and social issues in professional education (pp. 89-102). Albany, NY: State University of New York Press.

Kohlberg, L. (1976). Moral stages and moralization: The cognitive-developmental approach. In T. Lickona (Ed.), Moral development and behavior: Theory, research, and social issues (pp. 31-53). New York: Holt, Rinehart, & Winston.

Kolb, D. A. (1984). Experiential Learning: Experience as the Source of Learning and Development. Englewood Cliffs, NJ: Prentice Hall.

Komorita, N. I., Doehring, K. M., & Hirchert, P. W. (1991). Perceptions of caring by nurse educators. Journal of Nursing Education, 30(1), 23-29.

Kosowski, M. M. (1995). Clinical learning experiences and professional nurse caring: A critical phenomenological study of female baccalaureate nursing students. Journal of Nursing Education, 34(5), 235-241.

Kramer, B. J. (1993). Expanding the conceptualization of caregiver coping: The importance of relationship-focused coping strategies. Family Relations, 42, 383-391.

Kuh, G. D. (1995). The other curriculum: Out-of-class experience associated with student learning and personal development. The Journal of Higher Education, 66(2), 123-155.

Lazarus, R., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.

LeCompte, M. D., & Preissle, J. (1993). Ethnography and qualitative design in educational research (2nd ed.). San Diego: Academic.

Lewis, L. H., & Williams, C. J. (1994). Experiential learning: Past and present in New Directions for Adult and Continuing Education, 62, 5-15.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Thousand Oaks, CA: Sage.

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. In D. D. Williams (Ed.), Naturalistic evaluation (pp. 73-84). New Directions for Program Evaluation, No. 30. San Francisco: Jossey-Bass.

Logan, J. E. (1994). The National Student Nurses Association: A "professional clinical" arena for learning the culture and values of the nursing profession. Unpublished doctoral dissertation, Iowa State University, Ames, Iowa.

Mahoney, D. F. (1993). Gerontology in the nursing curriculum: Evolution and issues. Gerontology & Geriatrics Education, 13(3), 85-96.

Margolis, R. J. (1990). Risking old age in America. St. Paul, MN: Westview.

Mariano, C. (1990). Qualitative research: Instructional strategies and curricular consideration. Nursing and Health Care, 11(7), 354-359.

Markides, K. S., & Mindel, C. H. (1987). Aging and ethnicity. Thousand Oaks, CA: Sage.

Marks, N. F. (1996). Caregiving across the lifespan: National prevalence and predictors. Family Relations, 45, 27-36.

Marshall, C., & Rossman, G. B. (1995). Designing qualitative research (2nd ed.). Thousand Oaks, CA: Sage.

Matzo, M., & O'Reilly, M. (1993). Integrating gerontologic nursing into clinical settings: A new role for faculty. Geriatric Nursing, 13(2), 92-94.

Matzo, M., Perrin, K., & Williams-Burgess, C. (1993). Curriculum development in gerontological nursing education. Gerontology & Geriatrics Education, 13(3), 7-18.

Mayeroff, M. (1971). On caring. New York: Harper & Row.

Mayhew, K. C., & Edwards, A. C. (1936). The Dewey school: The laboratory school of the University of Chicago, 1896-1903. New York: D. Appleton-Century Co.

McCormick, T. (1994). Creating the nonsexist classroom: A multicultural approach. New York: Teachers College Press.

Merriam, S. B. (1988). Handling theory and literature reviews in case study research. In Case study research in education: A qualitative approach (pp. 53-66). San Francisco: Jossey-Bass.

Merriam-Webster's collegiate dictionary. (1974). Springfield, MA: Merriam-Webster.

Mezirow, J. D. (1981). A critical theory of adult learning and education. Adult Education, 32(1), 3-24.

Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis (2nd ed.). Thousand Oaks, CA: Sage.

Mitchell, G. J., & Heidt, P. (1994). The lived experience of wanting to help another: Research with Parse's method, Nursing Science Quarterly,7(3), 119-127.

Morse, J. M. (Ed.) (1991). Qualitative nursing research. Newbury Park, CA: Sage.

Nehls, N. (1995). Narrative pedagogy: Rethinking nursing education. Journal of Nursing Education, 34(5), 204-210.

Nelms, T. P., Jones, J. M., & Gray, D. P. (1993). Role modeling: A method for teaching caring in nursing education. Journal of Nursing Education, 32(1), 18-23.

Nelson, M. K. (1992). Geriatric nursing in the baccalaureate curriculum. Journal of Gerontological Nursing, 18(7), 26-30.

Noddings, N. (1984). Caring: A feminine approach to ethics & moral education. Los Angeles: University of California Press.

Nordgren, J., & Johnson, M. (1995). Using experiences of older adults to teach nursing students. Nurse Educator, 20(5), 34-38.

Oermann, M. (1994). Reforming nursing education for future practice. Journal of Nursing Education, 33(5), 215-218.

Parker, C. A., Widick, C., & Knefelkamp, L.L. (1978). Editors' notes: Why bother with theory? In L.L. Knefelkamp, C. Widick, & C. Parker (Eds.), Applying new developmental findings (New directions for student services #4) (pp. vii-xvi). San Francisco: Josey-Bass.

Perry, W. G., Jr. (1981). Cognitive and ethical growth: The making of meaning. In A.W. Chickering & Associates (Eds.), The modern American college: Responding to the new realities of diverse students and a changing society (pp. 76-109). San Francisco: Jossey-Bass.

Philipose, V. R. (1993). Is an elective course in gerontologic nursing viable for baccalaureate students? Geriatric Nursing, 14(2), 95-97.

Polit, D. F., & Hungler, B. P. (1997). Essentials of nursing research: Methods, appraisal, and utilization (4th ed.). Lippincott-Raven.

Psalm 71:9, Holy Bible: Today's English version. (1976). New York: American Bible Society.

Robertson, J. F., & Cummings, C. C. (1996). Attracting nurses to long-term care. Journal of Gerontological Nursing, 22(9), 24-32.

Rogers, C. R. (1969). Freedom to Learn. New York, NY: Merrill.

Sanford, N. (1962). Developmental status of the developing freshman. In N. Sanford (Ed.), The American College (pp. 253-282). New York: Wiley.

Sheffler, S. J. (1995). Do clinical experiences affect nursing students' attitudes toward the elderly? Journal of Nursing Education, 34(7), 312-316.

Schon, D. A. (1987). Educating the reflective practitioner. San Francisco, CA: Jossey-Bass.

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 118-137). Thousand Oaks, CA: Sage.

Simonson, C. L. S. (1996). Teaching caring to nursing students. Journal of Nursing Education, 35(3), 100-104.

Small, N. (1993). Facilitating student learning: Effective teaching strategies for baccalaureate education. In M. Burke & S. Sherman (Eds.), Gerontological nursing: Issues and opportunities for the twenty-first century (pp. 61-67). New York: National League for Nursing.

Sorrell, J. M. (1994). Remembrance of things past through writing: Esthetic patterns of knowing in nursing. Advances in Nursing Science, 17(1), 60-70.

Stake, R. (1988). Case study methods in educational research: Seeking sweetwater. In R. M. Jaeger (Ed.), Complementary methods for research in education. Washington, DC: American Educational Research Association.

Stumpf, N. E., Wollman, M. C., & Mezey, M. D. (1993). Gerontological education for baccalaureate nursing students. Gerontology & Geriatrics Education, 13(3), 73-84.

Taft, L. B. (1986). Teaching gerontologic nursing. Nurse Educator, 11(4), 11-15.

Thelen, H. A. (1972). Education and the human quest. Chicago: The University of Chicago Press.

Tisdell, E. J. (1993). Feminism and adult learning: Power, pedagogy and praxis. In S. B. Merriam (Ed.), An update on adult learning theory. (pp. 91-103). New Direction for Adult and Continuing Education, No.57. San Francisco: Jossey-Bass.

Tremmel, R. (1993). Zen and the art of reflective practice in teacher education. Harvard Educational Review, 63(4), 434-457.

Verderber, D. N., & Kick, E. (1990). Gerontologic curriculum in schools of nursing. Journal of Nursing Education, 29(8), 355-361.

Watson, J. (1988). Nursing: Human science and human care, a theory of nursing. New York: National League for Nursing.

Webster's dictionary. (1984). Springfield, MA: Merriam-Webster.

Wegner, C. (1978). Liberal education and the modern university. Chicago: University of Chicago Press.

Wells, T. J. (1992). Setting the agenda for gerontological nursing education. In C. Heine (Ed.), Determining the future of gerontological nursing education: Partnerships between education and practice (pp.6-16). New York: National League for Nursing.

Westberg, J., & Jason, H. (1996). Fostering learning in small groups: A practical guide. New York: Springer.

Wilson, A. L. (1993). The promise of situated cognition. New Directions for Adult and Continuing Education, 57, 71-79.

Wheatley, M. J., & Kellner-Rogers, M. (1996). A simpler way. San Francisco: Berrett-Koehler.

Wolcott, H. F. (1994). Transforming qualitative data: Description, analysis, and interpretation. Thousand Oaks, CA: Sage.

Yurchuck, E. R., & Brower, H. T. (1994). Faculty preparation for gerontological nursing. Journal of Gerontological Nursing, 20(1), 17-24.

IMAGE EVALUATION
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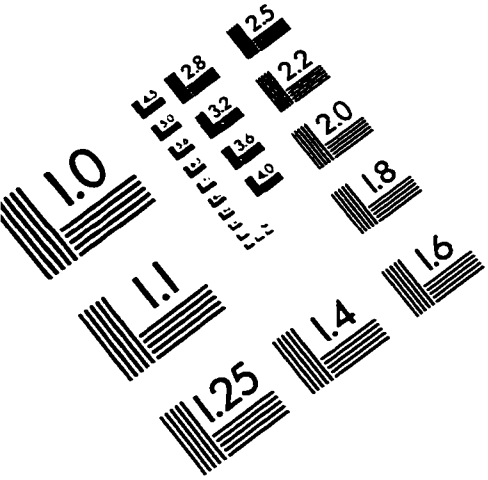

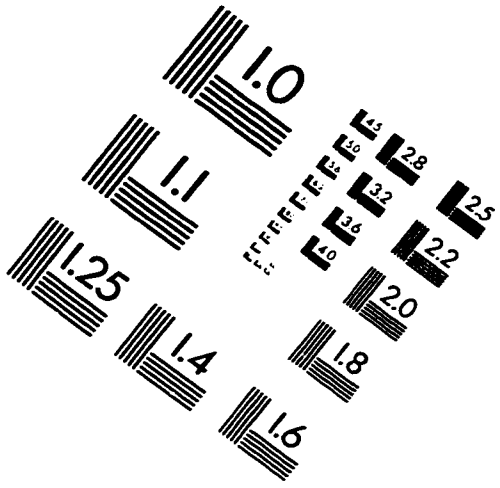

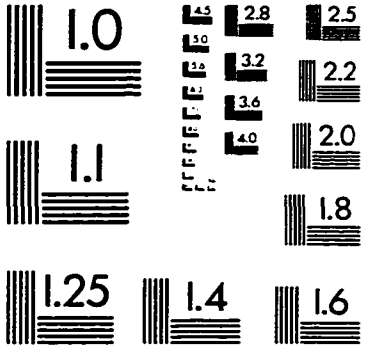

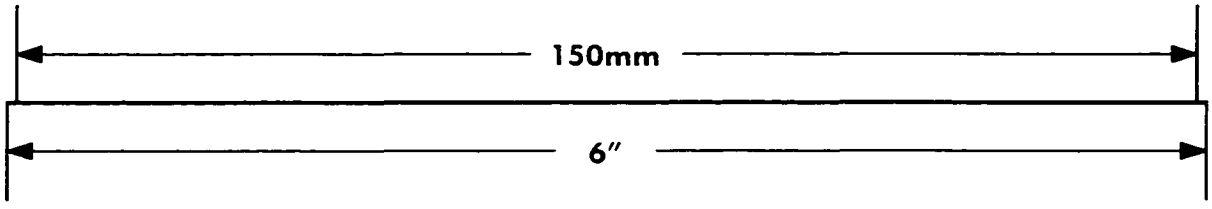

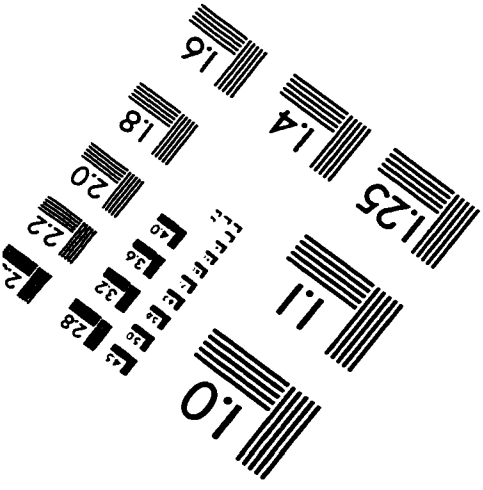

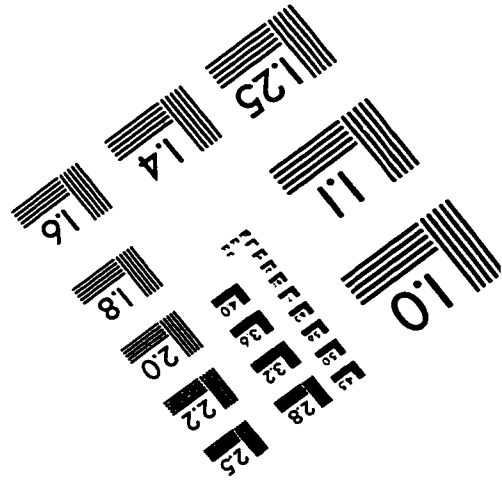

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